Abdul Ghafur bin Mohd Ibrahim v Pengarah, Hospital Kepala Batas & Anor

HIGH COURT (PULAU PINANG) — CIVIL SUIT NO 22–152 OF 2007
CHEW SOO HO JC
31 MAY 2010

Evidence — Documentary evidence — Admissibility of — Maker of documents overseas for further studies — Not reasonably practicable to secure attendance of maker at trial — Documents made contemporaneously — Whether documents admissible — Weight to be attached to documents — Evidence Act 1950 s 73A(2)

Evidence — Expert evidence — Medical opinion — Credibility of expert — Whether expert's past misconduct rendered expert a non-credible witness — Whether expert's untruthfulness showed that expert unreliable and tainted his evidence — Whether court to treat expert's evidence with great care and suspicion

Evidence — Presumption — Evidence Act 1950 s 114 — Illustration (g) — Non-calling of material witness — Witness overseas for further studies at time of trial — Not reasonably practicable to secure attendance of witness at trial — No withholding or suppression of evidence or witness — Whether presumption under s 114(g) ought not be invoked — Evidence Act 1950 s 114(g)

Tort — Negligence — Causation — Alleged medical negligence causing death of victim — Whether causal link between death of victim and negligence of tortfeasor established

Tort — Negligence — Medical negligence — Duty and standard of care — Whether Rogers v Whitaker test applicable — Whether medical practitioner negligent

The plaintiff-husband sued the defendants vicariously over the medical treatment and care administered by the servants and/or agents of the defendants to his wife ('the victim') at the Kepala Batas Hospital ('KBH'). The plaintiff's wife died as a result of subarachnoid haemorrhage ('SAH') due to the rupture of an aneurysm, a rare condition with a high mortality rate. The plaintiff claimed that negligence by the defendants' medical officers led to his wife's death and raised several grounds of negligence. The High Court had to,

inter alia, determine the following issues: (i) the admissibility and weight to be attached to certain medical records made by the attending physician — one Dr Suhaila — who was overseas for further studies at the time of trial; (ii) whether Dr Suhaila was negligent in failing to diagnose SAH when the victim sought treatment at KBH; (iii) whether a CT Scan ought to have been carried out before 4.30pm the day the victim sought treatment at KBH; (iv) whether there was any delay in sending the victim to the Seberang Jaya Hospital ('SJH') and the Penang Hospital; (v) whose (either SP2's or SD8's) expert medical opinion should the court prefer; and (vi) whether the plaintiff had proved causation.

Held, dismissing the plaintiff's claim with costs:

(1) The maker of exhs D19, D19A and D20 — Dr Suhaila — was in Australia for post-graduate studies at the time of the trial and it was not reasonably practicable to secure her attendance in court. Undue delay and high expenses would be incurred to subpoena her to attend the trial. Pursuant to s 73A(2) of the Evidence Act 1950, the court would exercise its discretion to rule D19 and D20 admissible. D19 consisted of Dr Suhaila's notes when she examined the victim and was the contemporaneous record of Dr Suhaila. D20 was the report Dr Suhaila had prepared on the instructions of SD7 — the Director of KBH. D19A was the transcript of Dr Suhaila's treatment notes (D19) and was transcribed by SD1 who testified and proved it herself. D19A was thus admissible. It was especially helpful to the court since there are difficulties in reading doctors' notes. D21 and D21A were respectively a copy and the original report of an investigation committee set up to investigate the plaintiff's complaints concerning the ambulance and were admissible (see para 8).

(2) The presumption under s 114(g) of the Evidence Act 1950 could not be invoked against the defendants for their non-calling of Dr Suhaila who was a material witness. There was no willful withholding or suppression of evidence or witness. The defendants had provided a reasonable explanation as to why Dr Suhaila was not called to testify — she was away in Australia for post-graduate studies. In any event, her treatment notes and report (exhs D19, D19A and D20) were produced as evidence and although cross-examination could not be had, the court would consider this fact when determining the weight to be attached (see para 8).

(3) From the evidence as a whole and upon the test propounded in *Rogers v Whitaker*, the actions taken by Dr Suhaila were reasonable of a competent or skilled medical officer. Her failure to diagnose the victim with SAH at 2.15pm on 10 October 2006 was reasonable and was not an act of negligence. From the referral letter from the doctor who referred the victim, he had not diagnosed the victim to have SAH

A although the symptoms of severe headache and vomiting were present. Dr Suhaila's decision to admit, observe and conduct further tests on the victim was a reasonable course of action before the diagnosis. Such acts should not be viewed as a breach of a duty of care and/or negligence as claimed by SP2 — the plaintiff's expert. There was no breach of the B duty of care by the defendants' servants or agents (see para 19); *Foo Fio Na v Dr Soo Fook Mun & Anor* [2007] 1 MLJ 593 referred and *Rogers v Whitaker* (1992) 175 CLR 479 followed.

(4) The fact that Dr Suhaila had not sent the deceased for a CT scan before 4.30pm was not an act of negligence. She had not neglected the victim C but had kept the victim under close observation and for further investigation with various tests conducted to rule out or confirm the victim's medical condition or diagnosis. Her actions were those of a reasonable doctor who is not a specialist or a neurosurgeon (see para 27). D

(5) Evidence from the defence as to the reasonable time taken to prepare the victim for the journey from KBH to SJH was not rebutted nor successfully challenged. The evidence had thus to be accepted as reasonable time in the instant case. On a balance of probabilities, there E was no evidence of any undue delay in sending the victim from KBH to SJH. There was also no merit in blaming the defendants for not sending the victim from SJH to the Penang Hospital when there was no approval from Penang Hospital, being the receiving hospital to do so. The medical officers could not be faulted for complying with the F rules and procedures or standard practice laid down by and enforceable in the public hospitals. SD2's decision to send the victim back to KBH after the scan at SJH was reasonable in the circumstances. Further, the 45 minutes taken to stabilise and prepare the victim for transportation from KBH to Penang Hospital after obtaining the necessary approval G could not be construed as unreasonable delay (see paras 30 & 32–33).

(6) From the evidence as a whole and on a balance of probabilities, the plaintiff had not proved his allegation of the faulty engine of the ambulance or the lack-of petrol in the ambulance that caused the delay in sending the victim from KBH to the Penang Hospital (see para 37). H

(7) The plaintiff's expert's (SP2's) past misconduct did not make him a non-credible witness. However by being untruthful in his evidence as to his last designation in the government hospital and concerning the grade he held before he resigned, SP2 had showed he was not a reliable I witness and as a matter of prudence, the court had to scrutinise his evidence with great care and suspicion. SP2 had also not undertaken any neurosurgical operation for the past two years save for some minor procedures. However the defendants' expert — SD8 — had vast working experience in neurosurgery and was the head of the

neurosurgery department at the country's main centre for neurosurgery. SD8 was undoubtedly more qualified and comprehensive in terms of practical experience as well as his knowledge in matters of neurosurgery compared to SP2. On a balance of probabilities, SD8's views or opinions were to be preferred to the views or opinions of SP2 (see paras 44 & 46).

(8) The plaintiff had failed to prove the causal link between the death of the victim and the alleged negligence or delay in sending the victim from SJH to Penang Hospital. Whether there was delay or not, it would not have changed the end result. The fact was that there was no prospect of saving the victim's life as SAH with cerebral aneurysm attracted almost 100% mortality. The plaintiff had failed to prove a breach of the duty of care or negligence on the part of the servants and/or agents of the defendants (see paras 58 & 60); *Dr Chin Yoon Hiap v Ng Eu Khoon & Ors and other appeals* [1998] 1 MLJ 57 (CA) referred.

[Bahasa Malaysia summary

Plaintif-suami telah menyaman defendan-defendan secara vikarius kerana rawatan perubatan dan jagaan yang dilaksanakan oleh pekerja-pekerja dan/atau ejen-ejen defendan-defendan terhadap isterinya ('mangsa') di Hospital Kepala Batas ('HKB'). Isteri plaintif telah meninggal dunia akibat pendarahan subaraknoid (a 'PSA') disebabkan aneurisme, keadaan yang jarang berlaku dengan tahap kematian yang tinggi. Plaintif mendakwa bahawa kecuaian oleh pegawai-pegawai perubatan defendan-defendan telah mengakibatkan kematian isterinya dan telah menimbulkan beberapa alasan-alasan kerana kecuaian. Mahkamah Tinggi perlu, antara lain, menentukan isu-isu berikut: (i) kebolehterimaan dan beban yang terdapat pada rekod-rekod perubatan tertentu yang dibuat oleh pakar perubatan yang merawat — Dr Suhaila — yang berada di luar negara untuk melanjutkan pelajaran pada masa perbicaraan; (ii) sama ada Dr Suhaila cuai kerana gagal mendiagnosis PSA semasa mangsa memerlukan rawatan di HKB; (iii) sama ada imbas CT patut dilakukan sebelum pukul 4.30 petang pada hari mangsa memerlukan rawatan di HKB; (iv) sama ada berlaku apa-apa kelewatan menghantar mangsa ke Hospital Seberang Jaya ('HSJ) dan Hospital Pulau Pinang ('HPP'); (v) pendapat pakar perubatan manakah (antara SP2 atau SD8) yang patut mahkamah pilih; dan (vi) sama ada plaintif telah membuktikan penyebaban.

Diputuskan, menolak tuntutan plaintif dengan kos:

(1) Pembuat eksh D19, D19A dan D20 — Dr Suhaila — berada di Australia kerana melanjutkan pelajaran lepasan ijazah pada masa perbicaraan dan ia tidak munasabah secara praktiknya untuk menjamin kehadirannya di mahkamah. Kelewatan melampau dan

perbelanjaan tinggi akan terpaksa ditanggung jika dia disampaikan sepina untuk hadir perbicaraan. Menurut s 73A(2) Akta Keterangan 1950, mahkamah akan melaksanakan budi bicaranya untuk memutuskan D19 dan D20 boleh diterima. D19 mengandungi nota-nota Dr Suhaila semasa dia memeriksa mangsa dan merupakan rekod semasa Dr Suhaila. D20 adalah laporan yang disediakan oleh Dr Suhaila atas arahan SD7 — Pengarah HKB. D19A adalah transkrip nota-nota rawatan Dr Suhaila (D19) dan telah ditranskripsikan oleh SD1 yang memberi keterangan dan membuktikan dirinya. D19A dengan itu boleh diterima. Ia membantu kepada mahkamah memandangkan terdapat kesukaran membaca nota-nota doktor. D21 dan D21A masing-masingnya adalah salinan dan laporan asal jawatankuasa siasatan yang ditubuhkan untuk menyiasat aduan-aduan plaintif berhubung ambulans dan boleh diterima (lihat perenggan 8).

(2) Andaian di bawah s 114(g) Akta Keterangan 1950 tidak boleh digunakan terhadap defendan-defendan kerana mereka tidak memanggil Dr Suhaila yang merupakan saksi penting. Tiada keterangan atau saksi yang ditahan atau disekat. Defendan-defendan telah memberikan penjelasan yang munasabah berhubung kenapa Dr Suhaila tidak dipanggil untuk memberi keterangan — dia berada di Australia untuk melanjutkan pelajaran lepasan ijazah. Dalam apa keadaanpun, nota-nota dan laporan rawatannya (eksh D19, D19A dan D20) telah dikemukakan sebagai bukti dan meskipun pemeriksaan balas tidak dapat dilakukan, mahkamah akan mengambilkira fakta ini apabila menentukan beban yang terdapat padanya (lihat perenggan 8).

(3) Berdasarkan keterangan secara keseluruhan dan ujian yang dikemukakan dalam kes *Rogers v Whitaker*, tindakan-tindakan yang diambil oleh Dr Suhaila adalah munasabah menurut pegawai perubatan yang kompeten atau mempunyai kepakaran. Kegagalannya mendiagnosis mangsa dengan PSA pada pukul 2.15 petang pada 10 Oktober 2006 adalah munasabah dan bukan tindakan yang cuai. Berdasarkan surat rujukan daripada doktor yang merujuk mangsa, dia tidak mendiagnosis mangsa mengalami PSA meskipun wujud tanda-tanda pening kepala yang teruk dan muntah. Keputusan Dr Suhaila untuk menerima, meneliti dan menjalankan ujian-ujian selanjutnya ke atas mangsa adalah tindakan yang munasabah sebelum mendiagnosis. Tindakan-tindakan sebegini tidak patut dilihat sebagai pelanggaran kewajipan berjaga-jaga dan/atau kecuaian sebagaimana didakwa oleh SP2 — pakar plaintif. Tiada pelanggaran kewajipan berjaga-jaga telah dilakukan oleh pekerja-pekerja atau ejen-ejen defendan-defendan (lihat perenggan 19); *Foo Fio Na v Dr Soo Fook Mun & Anor* [2007] 1 MLJ 593 dirujuk dan *Rogers v Whitaker* (1992) 175 CLR 4 diikut.

(4) Fakta bahawa Dr Suhaila tidak menghantar mangsa untuk imbas CT sebelum pukul 4.30 petang bukan tindakan yang cuai. Dia tidak mengabaikan mangsa tetapi telah meletakkan mangsa di bawah pemerhatian rapi dan untuk pemeriksaan selanjutnya dengan pelbagai ujian dilakukan untuk mengenepikan atau mengesahkan keadaan atau diagnosis kesihatan mangsa. Tindakan-tindakannya adalah sepertimana doktor yang munasabah yang bukan pakar atau pakar bedah saraf (lihat perenggan 27).

(5) Keterangan daripada pembelaan berhubung masa yang munasabah diambil untuk menyediakan mangsa untuk perjalanan dari HKB ke HSJ tidak dipatahkan mahupun dicabar dengan jayanya. Keterangan dengan itu diterima sebagai masa yang munasabah dalam kes ini. Atas imbangan kebarangkalian, tiada keterangan atau apa-apa kelewatan melampau menghantar mangsa dari HKB ke HSJ. Tiada juga merit dalam menyalahkan defendan-defendan kerana tidak menghantar mangsa dari HSJ ke HPP padahal tiada kebenaran dari HPP, yang merupakan hospital yang menerima untuk berbuat demikian. Pegawai-pegawai perubatan tidak patut dipersalahkan kerana mematuhi peraturan dan prosedur atau amalan piawai yang ditetapkan oleh dan dikuatkuasakan di hospital-hospital awam. Keputusan SD2 menghantar mangsa balik ke HKB selepas imbasan adalah munasabah. Bahkan masa 45 minit yang diambil untuk menstabil dan menyediakan mangsa untuk dibawa dari HKB ke HPP selepas mendapat kelulusan yang diperlukan tidak boleh ditafsirkan sebagai kelewatan yang tidak munasabah (lihat perenggan 30 & 32–33).

(6) Berdasarkan keterangan secara keseluruhan dan atas imbangan kebarangkalian, plaintif tidak membuktikan pengataannya tentang enjin rosak ambulans atau minyak ambulans yang tidak cukup yang menyebabkan kelewatan menghantar mangsa dari HKB ke HPP (lihat perenggan 37).

(7) Salah laku terdahulu pakar plaintif (SP2) tidak menjadikannya saksi yang tidak boleh dipercayai. Namun begitu disebabkan tidak bercakap benar dalam keterangannya berhubung kedudukan terakhirnya dalam hospital kerajaan dan berkaitan gred yang dipegangnya sebelum dia berhenti kerja, SP2 telah menunjukkan yang dia bukan saksi yang boleh dipercayai dan sebagai langkah berjaga-jaga, mahkamah perlu meneliti keterangannya dengan berhati-hati dan rasa syak. SP2 juga sudah dua tahun tidak melakukan apa-apa pembedahan saraf kecuali prosedur-prosedur kecil. Walau bagaimanapun pakar defendan-defendan — SD8 — mempunyai pengalaman pekerjaan dalam pembedahan saraf dan merupakan ketua jabatan pembedahan saraf di pusat utama pembedahan saraf negara. SD8 tidak diragui lebih

berkelayakan dan komprehensif dari segi pengalaman praktikal dan juga pengetahuannya dalam perkara-perkara tentang pembedahan saraf dibandingkan dengan SP2. Atas imbangan kebarangkalian, pandangan atau pendapat SD8 akan menjadi pilihan daripada pandangan atau pendapat SP2 (lihat perenggan 44 & 46).

(8) Plaintif telah gagal membuktikan kaitan penyebab antara kematian mangsa dan kecuaian yang dikatakan atau kelewatan menghantar mangsa dari HSJ ke HPP. Sama ada terdapat kelewatan atau tidak, ia tidak akan menukar apa yang berlaku akhirnya. Hakikatnya adalah bahawa tiada prospek untuk menyelamatkan mangsa kerana PSA dengan serebrum aneurisme hampir 100% akan menyebabkan kematian. Plaintif telah gagal membuktikan pelanggaran kewajipan berjaga-jaga atau kecuaian di pihak pekerja-pekerja dan/atau ejen-ejen defendan-defendan (lihat perenggan 58 & 60); *Dr Chin Yoon Hiap v Ng Eu Khoon & Ors and other appeals* [1998] 1 MLJ 57 (MR) dirujuk.]

Notes

For a case on medical negligence, see 12 *Mallal's Digest* (4th Ed, 2005 Reissue) para 1094.

For cases on admissibility of documentary evidence, see 7(1) *Mallal's Digest* (4th Ed, 2010 Reissue) paras 1187–1201.

For cases on causation, see 12 *Mallal's Digest* (4th Ed, 2005 Reissue) paras 851–869.

For cases on Evidence Act 1950 s 114, see 7(1) *Mallal's Digest* (4th Ed, 2010 Reissue) paras 2148–2149.

For cases on medical opinion, see 7(1) *Mallal's Digest* (4th Ed, 2010 Reissue) paras 1605–1606.

Cases referred to

Barnett v Chelsea and Kensington Hospital Management Committee [1969] 1 QB 428, QBD (refd)

Bolam v Friern Hospital Management Committee [1957] 2 All ER 118, QBD (refd)

Dominic Puthucheary & Ors (personal representatives of the estate of Thayalan a/l Kanapathipillai) v Dr Goon Siew Fong & Anor [2007] 5 MLJ 552; [2007] 5 CLJ 38, CA (refd)

Dr Chin Yoon Hiap v Ng Eu Khoon & Ors and other appeals [1998] 1 MLJ 57; [1998] 1 CLJ 533, CA (refd)

Dr KS Sivananthan v The Government of Malaysia & Anor [2001] 1 MLJ 35, HC (refd)

Folkes v Chadd (1782) 3 Doug KB 157 (refd)

Foo Fio Na v Dr Soo Fook Mun & Anor [2007] 1 MLJ 593, FC (refd)

Hassan bin Datolah v Kerajaan Malaysia [2003] 2 MLJ 425, HC (refd)

Hotson v East Berkshire Area Health Authority [1987] AC 750, HL (refd)

Hucks v Cole [1993] 4 Med LR 393, CA (refd)
International Insurance Co Ltd v Kusun Devi Mishra 1998 ALHC 2751 (refd)
International Times & Ors v Leong Ho Yuen [1980] 2 MLJ 86, FC (refd)
Khoon Chye Hin v PP [1961] MLJ 105, CA (refd)
Lechemanavasagar a/l S Karuppiah v Dr Thomas Yau Pak Chenk & Anor [2008] 1 MLJ 115; [2008] 3 CLJ 76, HC (refd)
Maynard v West Midlands Regional Health Authority [1985] 1 All ER 635, HL (refd)
Munusamy v PP [1987] 1 MLJ 492, SC (refd)
Payremalu a/l Veerappan v Dr Amarjeet Kaur & Ors [2001] 3 MLJ 725, HC (refd)
Queen, The v Silverlock [1894] 2 QB 766 (refd)
Rogers v Whitaker (1992) 175 CLR 479, HC (folld)
Sidaway v Bethlem Royal Hospital Governors and others [1985] 1 All ER 643, HL (refd)
Singapore Finance Ltd v Lim Kah Ngam (S'pore) Pte Ltd & Eugene HL Chan Associates (third party) [1984] 2 MLJ 202, HC (refd)
Udhaya Kumar a/l Karuppusamy & Anor v Penguasa Hospital Daerah Pontian & Ors [2004] 2 MLJ 661, HC (refd)
Wilsher v Essex Area Health Authority [1988] 1 All ER 871, HL (refd)
Wong Chop Saow v PP [1965] 1 MLJ 247 (refd)

Legislation referred to

Civil Law Act 1956 s 7
Evidence Act 1950 ss 73A, 73A(2), (6), 114(g)

Mohd Amir bin Abd Rani (Karpal Singh & Co) for the plaintiff.
Donald Joseph Franklin (Lee Boon Koon and Nor Azalina bt Razali with him) (Senior Federal Counsel, Attorney General's Chambers) for the defendants.

Chew Soo Ho JC:

FACTS

[1] The plaintiff is the husband of Yusnita bt Abas ('the deceased') who had passed away on 13 October 2006. This action is brought against the defendants pursuant to s 7 of the Civil Law Act 1956 (Act 67) for damages and bereavement for the plaintiff himself as dependant of the deceased as well as their three children aged 12 years, 9 years and 1 year 8 months respectively.

[2] Both the defendants are being sued for vicariously liable for the acts or performance of the medical officers and specialist who served in the Kepala Batas Hospital.

[3] On 10 October 2006, the deceased was first seen by doctor in Klinik Bersatu, Bertam Indah, Kepala Batas at about 12 noon for treatment of sudden onset of severe headache associated with vomitting. She was given treatment with Volteran infusion before she was referred to Kepala Batas Hospital. The deceased presented at Kepala Batas Hospital on the same date at about 1.55pm. At 2.15pm, deceased was seen by Dr Suhaila bt Ismail at the Emergency Department and was admitted for further observation and investigation. A Glasgow Coma Scale (GCS) which determines the level of consciousness of a patient was done and it showed a score of 14/15 which was insignificant for CT scan to be ordered. Blood sample of the deceased was taken but the test did not reveal any infection. At about 4.30pm Glasgow Coma Scale (GCS) score of the deceased suddenly dropped to 8/15 from the initial 14/15 during examination by Dr Suhaila. Her pupils became asymmetrical and she was unconscious. The deceased was intubated and subsequently sent to Seberang Jaya Hospital which has the CT scan facilities for CT scan to be done at 6.40pm; deceased was accompanied by Dr Nor Hafizah bt Ramli in the ambulance (SD2). The result of the CT scan showed that deceased was suffering from subarachnoid haemorrhage (SAH) and had massive bleeding in the brain. Arrangement was made to send the deceased to the Penang Hospital for neurosurgery. Meanwhile, the deceased was sent back to Kepala Batas Hospital at 7.40pm pending approval from Penang Hospital. Approval from Penang Hospital was obtained at 8.45pm and the deceased was sent by ambulance at 9.29pm. However, upon the deceased's arrival at the Penang Hospital, she was diagnosed by the neurosurgical team to have brain dead. No surgical intervention was then undertaken and conservative treatment was recommended. The deceased was brought back to Kepala Batas Hospital and admitted to Intensive Care Unit. The deceased finally passed away in the house on 13 October 2006 after being discharged at own risk.

[4] The plaintiff alleged that it was the negligence of the servants or agents of the first defendant that caused the death of the deceased pleading, inter alia, that they failed to diagnose the ailment of the deceased correctly and speedily from the symptoms and condition of the deceased, failed to send the deceased for further neurosurgical treatment as quickly as possible, failed to ward the deceased in the Intensive Care Unit for close observation, failed to ensure the ambulance was in proper condition and with petrol for emergency use, failed to send the deceased to Penang Hospital or to take steps to send the neurosurgeon to the Seberang Jaya Hospital to provide proper and best treatment to the deceased. Hence the plaintiff claims against the defendants for special damages of RM4,194 damages under s 7 of the Civil Law Act 1956 and punitive and exemplary damages of RM1m.

[5] The defendants' defence is that the deceased was given treatment in accordance with the medical practice which is reasonable and accepted in

Kepala Batas Hospital. The cause of death of the deceased was subarachnoid haemorrhage (SAH) due to rupture of aneurysm, a rare condition which caused the condition of the deceased to deteriorate fast and the mortality rate is high. The defendants deny all allegations of negligence and the damages as claimed. The deceased's death was inevitable as she was having massive bleeding in the brain that no surgical intervention could change the outcome.

THE ISSUES

[6] The defendants have raised six issues for the determination of this court which have been slightly amended and they read as follows:

(a) What is the weight to be attached to the documents notably D19, D19A, D20 and D21 tendered through the Record Officer of Kepala Batas Hospital?

(b) Was Dr Suhaila negligent in failing to make a diagnosis of SAH when the deceased presented herself at Hospital Kepala Batas and was examined by her at 2.15pm on 10 October 2006?

(c) Was there any indication to do a CT scan earlier than 4.30pm on 10 October 2006 before deceased's GCS score dropped to 8/15 with asymmetrical pupils?

(d) Whether there was any delay in sending deceased to Seberang Jaya Hospital and Penang Hospital?

(e) Whether in evaluating the evidence of both experts SP2 and SD8 which are apparently conflicting, which body of opinion that the court would prefer?

(f) Whether the plaintiff has proved causation ie whether it was the alleged delays that caused the death of the deceased?

[7] The plaintiff did not identify the issues specifically in his submission but the above issues raised by the defendants, to this court suffice, to cover all the plaintiff's submission.

EVALUATION AND FINDINGS

First issue: Weight of the documents D19, D19A, D20 and D21

[8] D19 is the patient's treatment card of Jabatan Kecemasan Hospital Kepala Batas as shown in bundle B pp 48–55 which is the official record prepared by Dr Suhaila Ismail, the medical officer in attendance of the deceased at the material time. D19A (bundle E pp 31–32) is the transcript of D19; this transcript was transcribed and typed by SD1, the Pembantu Rekod Perubatan

of Kepala Batas Hospital based on D19. D20 (bundle E pp 1–13) is Dr Suhaila Ismail's report as to the complaint as regards the patient Yusnita bt Abas, the deceased whereas D21 (bundle E pp 33–67) is the investigation report in respect of the plaintiff's complaint against Kepala Batas Hospital. The plaintiff's objection to exhs D19, D19A and D20 is basically because the maker of the documents ie Dr Suhaila Ismail was not called as a witness. The defendants relied on s 73A of the Evidence Act 1950 basing on the fact that Dr Suhaila Ismail is currently in Australia to further her post graduate studies and she is beyond the seas and it is not reasonably practicable to secure her attendance in court. Defence produced a letter from the Director of Kepala Batas Hospital dated 18 February 2010 (exh D18) through SD1 which confirmed that Dr Suhaila would be away for post-graduate studies in Australia from 27 July 2009 until 26 July 2010. If the defendants are compelled to, this court will have no doubt that Dr Suhaila's attendance would be able to be secured but it may mean that the defendants would have to bear high expenses to bring Dr Suhaila back from Australia and it may also mean that postponement may have to be sought since Dr Suhaila as scheduled would be in Australia until 26 July 2010. In the circumstances, this court would agree with the defendants' submission that it is not reasonably practicable to secure Dr Suhaila's attendance in court during the trial of this case which commenced on 8 March 2010 when Dr Suhaila was still in Australia. In the circumstances, this court is satisfied that there would be undue delay or that high expense would otherwise be caused if Dr Suhaila is to be subpoenaed to attend this trial. Pursuant to s 73A(2) of the Evidence Act 1950, this court therefore exercised its discretion to rule that D19 and D20 are admissible. In addition D19 was the contemporaneous records of Dr Suhaila when she examined and treated the deceased ie contemporaneous with the occurrence or existence of the fact stated therein (see s 73A(6) of the Evidence Act 1950) while D20 is the report prepared on the instructions of SD7, Dr Mohd Sabri bin Othman, the Director of Kepala Batas Hospital at the relevant time, who had identified D20 to be the report received from Dr Suhaila and Dr Suhaila had duly signed D20. This court finds no doubt that D20 is from Dr Suhaila and not anyone else. plaintiffs objection to D19A is because D19A was derived from D19 which contained the treatment notes of Dr Suhaila who was not called as a witness being the maker of the said records. SD1 who transcribed D19 into D19A is indeed the maker of D19A. She did the transcript because she was familiar with Dr Suhaila's handwriting. Whether SD1 had or had not transcribed accurately the records or notes of D19 is certainly for the plaintiff to challenge during cross-examination of SD1 but in so far as the transcript is concerned, it is admissible since SD1 who is the maker had testified and proved it herself. This court therefore rules that D19A is admissible. According to Mr Franklin Donald, senior federal counsel, who appeared for the defendants, the purpose of this transcript is to assist the court and the parties as to the handwritten treatment notes of Dr Suhaila vide D19. This court agrees that it does pose some difficulties to read doctor's notes. D19A will definitely assist this court

and the parties. To this court, there is no reason for SD1 to add, substract or change the written records of Dr Suhaila as she was merely requested to transcribe in type-written form. Learned counsel for the plaintiff submitted that s 114(g) of the Evidence Act 1950 ought to be invoked to draw an adverse inference on the defendants for non-calling of Dr Suhaila who is a material witness in this case. It must be noted that for the presumption under s 114(g) to be invoked, there must be willful withholding of evidence or suppression of evidence and not merely on account of failure to obtain evidence; see *Sarkar's Law of Evidence* (15th Ed, 1999), Vol 2 at p 1678. Similarly, there must be willful withholding or suppression of an important or a material witness and not just any witness when the witness was not called to testify; see *Munusamy v Public Prosecutor* [1987] 1 MLJ 492 (SC). In the instant case, Dr Suhaila was away in Australia to further her studies. To reiterate, uprooting her from Australia would cause great expenses and might cause undue delay to the trial since she will be in Australia until 26 July 2010 as scheduled. There is thus reasonable explanation by the defendants as to why Dr Suhaila was not called to testify. Nevertheless, her treatment notes D19 as well as her report of the whole event, D20 were tendered before the court. D19, in particular was the contemporaneous record as to the examination, treatment, observation etc of the deceased. It is the best evidence and it is produced as evidence. There is no withholding of even the best evidence. In *International Insurance Co Ltd v Kusun Devi Mishra* 1998 ALHC 2751 at p 3753, it was held that if a party in possession of the best evidence which would throw light in controversy withholds it, the court can draw an adverse inference against him notwithstanding that the onus of proof does not lie on him. I accept the explanation of the Defence as to the non-calling Dr Suhaila. However, the absence of Dr Suhaila will mean that her evidence vide D19 and D20 was not subjected to cross-examination. This court will have to take into consideration this fact in determining the weight to be accorded to the evidence of D19 and D20. On this point, as stated earlier, D19 is the contemporaneous notes at the time of examination, treatment etc of the deceased, it is a record of facts that transpired at the material time and not a record done subsequently or a record of opinion. It is indeed akin to a record of fact finding. I do not find any reason to doubt or suspect that there is any fabrication of such contemporaneous record. Hence, I hold that due weight ought to be attached to D19. However, D20 is a subsequent written statement by Dr Suhaila when she was directed to put up upon a complaint having been made by the plaintiff. Such statement untested through cross-examination must be viewed with care and it will only be proper that the weight of it is to be deferred at the end of the whole case after hearing all evidence. Thus, I will defer the weight to be given to D20 subsequently after considering the whole case having regard to s 73A(6) of the Evidence Act 1950. D21 is a report from an investigation committee set up by the Penang Health Department to investigate the plaintiff's complaint of the condition of the ambulance as well as the allegation of the ambulance which was supposed to take the deceased to Penang Hospital, being out of petrol. The

A B C D E F G H I

plaintiff's objection is that the maker of this report was not called. Evidence of SD1 has shown that this report was a document kept in the Bahagian Rekod of the Kepala Batas Hospital for which she had the custody and SD7, the Director of Kepala Batas Hospital at the material time had full knowledge of D21 as he was extended a copy of the same during his tenure as the Director. SD7 produced the original which was marked as D21A. I therefore rule that D21 and D21A are admissible with the production of D21A, the original report which is primary evidence that was in the possession of SD7 who had received it in his capacity as Director of Kepala Batas Hospital. From the cross-examination on SD7, there is nothing to suggest the inaccuracy of the contents of this report nor that this report is prejudicial to the plaintiff but that it was an initial internal investigation by Kepala Batas Hospital as to what transpired and whether there was faulty ambulance engines and whether the ambulance was out of petrol as complained by the plaintiff. I find no reason to doubt this report and therefore due weight ought to be given to D21 and D21A.

Second issue: Was Dr Suhaila negligent in failing to make a diagnosis of SAH when deceased presented herself at Kepala Batas Hospital and was examined by her at 2.15pm on 10 October 2006?

[9] The undisputed fact is that before going to Kepala Batas Hospital on 10 October 2006, the deceased had first visited Klinik Bersatu complaining of sudden onset of severe headache associated with vomitting and was given injection of Volteran (an analgesic or a painkiller). This information can be found in the referral letter of the same date from Klinik Bersatu to the Kepala Batas Hospital (exh P2).

[10] From the patient's treatment card of the deceased, D19, it shows that the deceased presented herself at the Emergency Ward of Kepala Batas Hospital at 1.55pm the same day and was seen by Dr Suhaila at 2.15pm. As per the record in D19, the deceased's complaint to Dr Suhaila was dizziness since that morning associated with abdominal pain. The deceased's Glasgow Coma Scale ('GCS') score then was recorded as 14/15. On examination, Dr Suhaila found the deceased to be sleepy but rousable (D19 at p 32 bundle E). From D19 as well as the deceased's medical report prepared by Dr Suhaila as in bundle B pp 9–10 of the agreed bundle of documents, it was also noted that the deceased's pupils were equal and reactive. A fundoscopy done showed that no papilledema (swelling of the first part of the optic nerve) was seen. The deceased was able to move all her four limbs and other parts of the examination were unremarkable. Dr Suhaila also ordered baseline blood investigations (p 9 bundle B) with results noted. The deceased was kept for observation and was placed on a bed in the resuscitation room (referred to evidence of SD2, Dr Nor Hafzah bt Ramli in cross-examination when she saw the deceased at about

5pm). According to D20, Dr Suhaila's report, she had directed the deceased to be placed at the space in front of the doctor's room for observation of the deceased's GCS score as well as for the baseline blood investigation. Although the plaintiff said that the deceased was lying on a bed in 'ruang rehat' in the Emergency Department, the important fact is that the deceased was admitted and kept in the Emergency Department for observation by Dr Suhaila. The plaintiff's evidence is indeed consistent with Dr Suhaila's report that the deceased was placed at a 'ruang pemerhatian'. From the record D19 at bundle B at p 55 at column Management/Plan, Dr Suhaila had recorded that at 4.30pm, the deceased's GCS score had dropped to 8/15. This was confirmed by SD2, Dr Nor Hafizah who saw the deceased at about 5pm and noted the deceased's GCS score to be 8/15 — (E2/V2/M4); (D23 Q & A.5). According to Dr Suhaila's report D20 at bundle E at p 3, between 2.20pm till before 4.30pm, she had seen the deceased twice and found deceased's GCS score to remain at 14/15. The plaintiff said he arrived at the Kepala Batas Hospital at 2.15pm and confirmed that at about 2.15pm, Dr Suhaila had examined the deceased. Between 2.20pm to before 4.30pm, the plaintiff said he was not certain whether Dr Suhaila had seen the deceased twice but was certain that Dr Suhaila had seen deceased again once because Dr Suhaila had asked him whether the deceased had headache before that occasion. The plaintiff was with the deceased at the material time. He did not deny that Dr Suhaila had revisited the deceased twice while deceased was kept under observation but confirmed at least once that he remembered. Since Dr Suhaila's report that she visited the deceased twice between 2.20pm to before 4.30pm was not refuted, I find it probable that she could have visited the deceased twice as she had so reported in D20 and accept this part of her evidence. The plaintiff stated in cross-examination that he had spoken to the deceased until about 5pm that day and agreed that it was after 5pm that the deceased's condition had deteriorated. Dr Suhaila in her report D20 said that during 2.20pm to before 4.30pm, she visited the deceased twice and found her GCS score to remain at 14/15 and it was only at 4.30pm that she found the deceased's level of consciousness to drop to 8/15 (E2/V2/M4). This aspect of Dr Suhaila's report is quite consistent with the plaintiffs evidence that his wife was still able to speak to him until about 5pm. Subsequent to finding that the deceased's GCS score had dropped to 8/15, evidence shows that Dr Suhaila had directed and made arrangement to send the deceased to the nearest hospital ie Hospital Seberang Jaya which has the CT scan facilities for CT scan of the deceased's brain to be conducted since there is no such facility in Kepala Batas Hospital. SD2 was contacted to accompany the deceased.

[11] The question is whether Dr Suhaila is doing what she had done on the deceased after having examined her at 2.15pm, was negligent not to have diagnosed the deceased to have suffered from subarachnoid haemorrhage (SAH) of the brain. SP2, Dr K Anil Shankar, the plaintiff's expert witness, a consultant neurosurgeon, in his oral evidence and in his expert opinion report,

exh P11, was of the view that Dr Suhaila had failed to pick up the symptoms of sentinel or warning headache of SAH associated with vomitting and the deceased's past history of headaches which created suspicious of SAH. The defendant's expert witness SD8, Dr Johari Siregar bin Adnan, a senior consultant neurosurgeon and Head of Neurosurgery Department, Sultanah Aminah Hospital, Johor Bahru as well as the National Head of Neurosurgery, Ministry of Health, had explained at great length vide his expert opinion contained in exh D34, in his witness statement D33 and his oral evidence in court that there was no basis or indication for Dr Suhaila to have made the diagnosis of SAH from the time of the deceased's presentation at Hospital Kepala Batas till before 4.30pm. SD8 gave his reasons that firstly, the deceased's complaint to Dr Suhaila was that of dizziness but not of severe headache although her referral letter from Klinik Bersatu mentioned the onset of severe headache. The deceased was injected with painkiller Volteran at Klinik Bersatu which could have probably relieved her earlier complaint of severe headache but resulted in her dizziness. Secondly, the deceased's GCS score of 14/15 which is insignificant in case of SAH, her pupils being symmetrical and responsive to light stimulus, drowsy or sleepy but arousable, absence of papilledema on fundoscopic examination and the absence of any abnormalities of plantar response on her feet show that the deceased's level of consciousness was good and there was no abnormalities on the neurological system of the deceased upon examination by Dr Suhaila. Thirdly, the results of the blood test, urine test and other investigations were essentially within normal limits except for the elevated total white cells count in the blood referring to bundle B of the agreed documents pp 56–59, 76–79 (D34). SD8 describe the most common symptoms of SAH is headache, typically described as sudden onset, severe and the worst ever headache experienced in life. The other associated symptoms are nausea, vomitting, neck pain and neck stiffness. SD8 referred to medical literature on *Aneurysmal Subarachnoid Haemorrhage* by Jonathan A Edlow, Adel M Malek and Christopher S Ogilvy; The Journal of Emergency Medicine 2008, Vol 34 No 3 pp 237–251 (exh D32 p 13 paras 1 and 2), to substantiate his view. In the instant case, except for dizziness and abdominal pain, the symptoms of SAH were not present. SD8 added that even the most common symptom of severe headache may not exclusively be attributed on account of the presence of SAH. Headache can be attributed to many other medical conditions. He referred to medical literature D32 p 11 in support. SD8 also pointed out that from the statistics provided in the medical literature, only 1 in 100 patients with headache presenting at the Emergency Departments has been found to have SAH and of patients with severe, abrupt onset headaches and normal neurological examination, only about 10% have been found to have suffered SAH (D32 pp 10 and 11). Referring to a review article on *Avoiding Pitfalls in the Diagnosis of Subarachnoid Haemorrhage* by Jonathan A Edlow, MD and Louis R Caplan, MD, it was cited that 'among all patients with headache who presented to emergency departments, retrospective studies have found that approximately 1% had subarachnoid

haemorrhage. One prospective study put that figure at 4%. Two prospective studies found that if only patients with 'the worst headache' of their lives and a normal neurologic examination were considered, 12% of such patients had subarachnoid haemorrhage. This proportion increased to 25% when patients whose examinations were abnormal were included' (D32 at p 33). SD8 thus opined that in a large proportion of cases, severe headache is not caused by SAH. SD8 added further that due to the low evidence of SAH, it is not commonly seen by emergency department's doctors. Referring to medical literature titled *Easily Missed? Subarachnoid Haemorrhage* by Graeme J Hankey and Mark R Nelson 2009 BMJ Publishing Group, it is reported that 'the incidence of SAH is about seven per 100,000 person years. On average a full time general practitioner with a list of 200 patients will see one patient with the condition every seven years. Subarachnoid Haemorrhage is missed in 20–50% of patients at first presentation'. Hence SD8 said that on account of the low incidence of SAH, the wide spectrum of medical conditions which are associated with severe headaches and vomitting as well as its uncommonness to the attending doctors at the emergency departments, the chances of misdiagnosis is high and common. He finds support for his view in The Journal of Emergency Medicine at D32 at p 11.

[12] On SP2's, Dr Anil's ascertain that Dr Suhaila had failed to pick up the symptoms of sentinel or warning headache of SAH with vomitting; SD8 stated that the symptoms of sentinel or warning of severe headaches with vomitting which the deceased complained at the Klinik Bersatu was observed, noted and recorded by Dr Suhaila referring to bundle B pp 9, 48, 55, 88 and 100. The deceased however did not restate her earlier complaint when she was seen by Dr Suhaila at Kepala Batas Hospital probably because the severe headache was relieved by the injection of Voltaren at Klinik Bersatu. Although Dr Suhaila did not list out the causes of the sentinel or warning headache, she had recognised that the deceased had a serious condition or headache that required medical attention. For that, she had taken proper action to admit, assess and treat the deceased with infusion fluid, blood investigations etc referring to exh D19. Since Dr Suhaila was not a neurologist or a specialist and it was an area beyond her expertise, she had rightly consulted her specialist Dr Kamil and took proper action to intubate and stabilise the deceased when she deteriorated neurologically at 4.30pm. In the circumstances, Dr Johari Siregar, SD8 is of the view that Dr Suhaila's actions were in accordance with neurological practice and more so when she was a medical officer at Hospital Kepala Batas. To allege that Dr Suhaila had failed to pick up the deceased's past history of headaches which created suspicious of SAH, according to SD8, is a completely baseless assertion for reason that from the referral letter of Klinik Bersatu (P2 — bundle B at p 47), the deceased had clearly denied any past headaches. There is also no record of such complaint of headaches anywhere in Kepala Batas Hospital except medical report at p 9 of bundle B where Dr Suhaila indicated that the deceased had a few attacks of headaches in the past. That itself, according to

SD8 is a weak link with the presence of SAH. SD8 opined that on the various medical literatures referred to, the more useful signs and symptoms which link to SAH would be sudden onset of worst headache, nausea and vomitting, meningism and neck stiffness. SD8 also refutes Dr Anil's assertion that Dr Suhaila had failed to pick up raised blood pressure and raised white blood count as a sign of raised intracranial pressure on ground that raised blood pressure and blood results have no useful links to SAH and is not supported by authoritative medical literature; the more useful investigation to link with SAH would be lumbar puncture and GT brain scan which was carried out at the Seberang Jaya' Hospital when the deceased's GCS score dropped to 8/15 which is an indication of neurological signs. SD8 concludes his expert opinion by saying that taking into consideration of the guidelines available, the experience of the doctors in Kepala Batas Hospital and the availability of the medical resources in the hospital, the treatment given to the deceased at Kepala Batas Hospital is within acceptable standards of neurological practices.

[13] What had transpired at the Kepala Batas Hospital commencing from the deceased's presence at 1.55pm, her physical examination by Dr Suhaila at 2.15pm, her admission for observation, taking of GCS score, blood investigations etc are not substantially disputed by the parties. The main complaint of the plaintiff herein this issue is the failure of Dr Suhaila to diagnose-that the deceased was suffering from SAH relying principally on the evidence of his expert witness, Dr Anil, a private consultant neurosurgeon, SP2. Dr Anil in his witness statement P10 stated the history of the case as follows:

> According to history from the Hospital Kepala Batas, this person was admitted with history of Severe Headaches with Vomitting signifying raised Intra-Cranial Pressure (ICP). She had a past history of Recurrent Headaches and this present admission was her worst headache she experienced. Her Glasgow Coma Scale on admission was 14/15 signifying she was confused & drowsy. Her BP was high and her Total White Cell Count was 19800.

[14] On the above history as noted by him, he concluded that:

> The History is classical of a Spontaneous Sub-arachnoid Haemorrhage (SAH) which has been graded under a different Classification of Neurosurgery-World Federation of Neurological Surgeons i.e WFNS from Grade 1 to 5 The WFNS Grades Scores for SAH are follows:

WFNS Grade	Glasgow Coma Scale (GCS)	Major Neurological Disability
Grade 1	15	None
Grade 2	13–14	None
Grade 3	13–14	Positive/Present
Grade 4	7–12	Present/Absent

Grade 5	3–6	Present/Absent

[15] Nevertheless, basing on the deceased's GCS score at admission of 14/15, he graded it to be under WFNS Grade 2. Since Dr Anil had graded the deceased WFNS classification to be at Grade 2 with the GCS score of 14/15 before it deteriorated to 8/15 at about 4.30pm and under Grade 2 in the chart provided by him above, it is clearly written that major neurological disability is indicated as 'None'; this court finds it difficult to comprehend how Dr Anil could conclude from the history that the deceased's case is a classical case of Spontaneous Sub-arachnoid Haemorrhage when the deceased's GCS score of 14/15 does not indicate any major neurological disability as he himself had classified it. In short, what Dr Anil said on the one hand is that from the history, it was a classical case of Spontaneous SAH but on the other hand, he classified the deceased's case under the WFNS Grade to be Grade 2 which is without any major neurological disability. His views do not seem to synchronise with one another. Further, this court finds that Dr Anil had not taken into account any of the fact that upon examination by Dr Suhaila, the deceased merely complained of dizziness associated with abdominal pains but not severe headache or the worst headache of her life associated with vomitting; the deceased's pupils were equal and reactive; the deceased was sleepy but rousable and the fact that the deceased was injected with Volteran at Klinik Bersatu. There was also no comment made by him that a fundoscopy done by Dr Suhaila or ordered by her which showed no papilloedema as well as the fact that the deceased was able to move all her four limbs. Adding to all those findings, GCS score of the deceased during examination was 14/15 in WFNS Grade 2 and remained the same before 4.30pm. Can Dr Suhaila be faulted to be negligent in not diagnosing the deceased to suffer from SAH but to keep the deceased closely for further observation and blood tests? I find that Dr Anil had jumped into conclusion without taking into proper consideration all relevant factors? And other relevant surrounding circumstances of the case which should not have come from an expert. I tend to accept Dr Johari Siregar's view which is more reasonable and well substantiated that from all the symptoms above, there was no abnormality on the neurological system of the deceased at that point in time as the symptoms for SAH are basically the onset of severe headache or the worst ever headache experienced in life associated with symptoms such as nausea, vomitting, neck pain and neck stiffness. He had also supported his views with the relevant and authoritative medical literatures as in exh D32. From the medical literatures referred to by Dr Johari Siregar, this court is enlightened with the fact that mere headache or severe headache itself may not necessarily be attributed by SAH upon the statistic or percentage of such cases published in the medical literatures. Indeed SAH is rare: about seven out of 100,000 persons per year, and may not be easily or readily detected upon examination: on average, a full time general practitioner with a list of 2,000

patients will see one patient with condition every seven years (D33 Q & A.44). Dr Siregar's explanation that the deceased did not restate that she had onset of severe headache when being examined by Dr Suhaila was probably because of the injection of Voltaren at Klinik Bersatu which had relieved her complaint. Without this onset of severe headache recurring at the time Dr Suhaila examined the deceased but for mere dizziness, the very vital symptom of SAH could not be said to be present and ignored by Dr Suhaila as such complaint could probably have been taken care of by the Volteran injection. I would tend to accept Dr Johari Siregar's view that although Dr Suhaila did not list down the causes of warning headache, she has nevertheless recognised the fact that the deceased might have a serious condition or a headache that required medical attention. She had admitted the deceased, assessed and treated the deceased with infusion fluid, carried out blood investigations and monitoring the deceased's GCS score. To this court, the various actions taken by Dr Suhaila indicate that she did not ignore the earlier history of the deceased at Klinik Bersatu which was narrated in the referral letter although the deceased did not advance similar earlier complaints at 2.15pm at Kepala Batas Hospital. From the plaintiff's evidence which confirmed that Dr Suhaila had seen the deceased at least once after 2.15pm to before 4.30pm and the non-denial that Dr Suhaila had in fact seen the deceased twice, I find no reason to doubt Dr Suhaila's report vide D20 that she had visited the deceased twice and had found her GCS score to remain 14/15 on both occasions. From all the examinations and findings between 2.15pm until before 4.30pm, it appears that the symptoms of SAH ie severe headache, vomitting or nausea, neck pain or neck stiffness, etc were not manifest. Must Dr Suhaila, a medical officer and not a neurosurgeon have necessarily diagnosed the deceased to have suffered from SAH in the circumstances?

[16] In *Foo Fio Na v Dr Soo Fook Mun & Anor* [2007] 1 MLJ 593, our Federal Court had taken a paradigm shift from the salutary *Bolam* test as enunciated in *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118 and held that the *Rogers v Whitaker* test as propounded in *Rogers v Whitaker* (1992) 175 CLR 479 by the High Court of Australia to be a more appropriate and a viable test of this millennium. This test is as follows:

> In Australia, it has been accepted that the standard of care to be observed by a person with some special skill or competence is that of the ordinary skilled person exercising and professing to have that special skill. But, that standard is not determined solely or even primarily by reference to the practice followed or supported by a responsible body of opinion in the relevant profession or trade. Even in the sphere of diagnosis and treatment, the heartland of the skilled medical practitioner, the *Bolam* principle has not always been applied. Further, and more importantly ... the courts have adopted the principle that, while evidence of acceptable medical practice is a useful guide for the courts, it is for the courts to adjudicate on what is the appropriate standard of care ...

[17] Drawing the distinction between the test of negligence based on reasonable competent man and that of ordinary skilled man, our Federal Court in the same case has endorsed the passage at p 95 of Michael Jone's book on *Medical Negligence* (1996 Ed) at pp 610–611 which reads as follows:

> Finally, we make reference to Michael Jone's book on *Medical Negligence* (1996 Ed) p 95 that seems to suggest that there is a distinction between the test of negligence based on the reasonable competent man and that of the ordinary skilled man. The former makes it clear that negligence is concerned with the departures from what ought to have been done in the circumstances which is measured by reference to a hypothetical 'reasonable doctor' and the latter placed considerable emphasis on the standards which are in fact adopted by the profession. He emphasises that the point is for the court to determine what the reasonable doctor would have done, not the profession. What the profession does in a given situation will be an important indicator of what ought to have been done, but it should not necessarily be determinative. In the final analysis, the court should set the standard of care in, negligence, drawing upon the evidence presented. The *Bolam* test fails to make this important distinction between the reasonable competent doctor and the ordinary skilled doctor.

[18] The Federal Court also stated that 'at common law, the duty of care owned by a doctor arises out of his relationship with his patient. Without the doctor and patient relationship, there is no duty on the part of the doctor to diagnose, advice and treat his patient'. To echo what the learned author Michael Jone's words, the *Rogers v Whitaker* test would seem to be the test of negligence based on the reasonable competent or skilled man measured by reference to a 'hypothetical doctor' in the sense that it is for the court to determine what the reasonable doctor would have done and not the profession; see *Rogers v Whitaker*. This court will adopt the duty of care as expressed by the Federal Court above-quoted in the present case. Applying the *Rogers v Whitaker* test in the present case, will Dr Suhaila be held to be negligent in not diagnosing the deceased to have SAH upon her admission to the Kepala Batas Hospital? From the facts of this case, from the time of examination of the deceased at 2.15pm till before 4.30pm, as stated above, apart from what had been stated in the referral letter by Klinik Bersatu, the symptoms of SAH were not significant and there were no abnormalities noted in the neurological examination. Nevertheless, Dr Suhaila had admitted the deceased for close observation. Within the span of about two hours, Dr Suhaila had checked on the deceased and found her GCS to remain at 14/15. This court also cannot disregard the fact that there are limitations in the resources in Kepala Batas Hospital in that there was no CT scan facility and that there must be justification by a referring doctor of a patient for CT scan before the radiologist referred to can accept the patient for CT scan. In the absence of the significant signs of SAH having developed or recurred upon examination of the deceased till her observation before 4.30pm, with all other signs upon examination and tests carried out to be ostensibly normal with GCS 14/15, lightly drowsy but

arousable, pupils equal and reactive, no papilledema seen from fundoscopy, ability to move all four limbs etc, I am of the view that it may be more probable that Dr Suhaila would not be able to justify her request for CT scan to be done or that CT scan might not be warranted. From the various actions taken by Dr Suhaila in attending and admitting the patient, assessing and treating her in the circumstances of this case when the significant symptoms of SAH did not manifest between 2.15pm to before 4.30pm, this court upon finding of facts, finds it reasonable that what Dr Suhaila had done on the deceased would be that of a reasonable and competent doctor or medical officer in a public hospital where there is no CT scan facility. The fact that Dr Suhaila had failed to diagnose the deceased to have SAH at these hours, in the facts and circumstances of this case, cannot be said to be negligent based on the standard of a reasonable competent or skilled person. By Dr Suhaila's act to admit the deceased and to carry out the fundoscopy, blood investigations and with GCS score of the deceased being monitored, it is reasonable to infer that she had the seriousness of the deceased's condition in mind and was taking the necessary measures to arrive at a proper diagnosis. From medical literatures and Dr Johari Siregar's evidence, it may not be frequent and easy to detect SAH. It must also be accepted the fact that Dr Suhaila was not a neurosurgeon nor from the neurological department. She might be suspicious or conscious of the deceased's serious condition to admit the deceased for further tests and observation in spite of the fact that the deceased did not complain of severe headache and vomitting upon examination by her at 2.15pm but the absence of the symptoms of SAH and the non-recurrence of the earlier complaints of the deceased will render uncertainty for Dr Suhaila to conclude a diagnosis of SAH. This court is of the view that she had exercised due care and caution of a reasonable competent and skilled doctor although she did not diagnose the deceased's aliment at that time.

[19] From the evidence as a whole and upon the test of *Rogers v Whitaker*, this court is of the view that the actions taken by Dr Suhaila was reasonable of a competent or skilled medical officer and her failure to diagnose the deceased with SAH at 2.15pm on 10 October 2006 is reasonable and not an act of negligence. From the referral letter P2 from Klinik Bersatu, the doctor who referred the deceased similarly did not diagnose the deceased to have SAH although the symptoms of severe headache and vomitting were present. Therefore, to admit, observe and conduct further tests on the deceased would seem a reasonable course of action before the diagnosis, which Dr Suhaila had done. Such acts should not be viewed as a breach of a duty of care and/or negligence as claimed by SP2, Dr Anil. This court finds that there is no breach of the duty of care by the defendants' servants or agents.

Third issue: Was there any indication to do a CT scan earlier than 4.30pm on 10 October 2006 before the deceased's GCS score dropped to 8/15 with asymmetrical pupils?

[20] The plaintiff's contention is that there was a delay in making the

decision to send the deceased for a CT scan of the brain earlier than 4.30pm while the defendant's contention is that there was no indication to do so and indication only arose at 4.30pm when the deceased's GCS score dropped to 8/15 and her pupils became asymmetrical. The defendant submitted that exh D19 clearly shows that the deceased's GCS score at the time of her presentation at the Kepala Batas Hospital was 14/15 and that between 2.20pm and before 4.30pm, Dr Suhaila had observed the deceased twice and found her level of consciousness remained at 14/15. This fact was supported by the plaintiff's evidence as well as SP2, Dr Anil who said that from the plaintiff, he came to understand the deceased was speaking to the plaintiff till 5pm and only after this period, her coma scale dropped to 8/15 with unequal pupils. The defendants relied on Dr Johari Siregar's evidence on the actions taken by Dr Suhaila after completion of her examination on the deceased and whether Dr Suhaila was justified in not ordering a CT scan upon admission. Dr Johari Siregar said at D33 p 7 Q & A 14 in his witness statement:

> The decision to admit the deceased for observation and start her on infusion fluid was an appropriate one. It indicates that she recognized that the deceased was not suffering from a simple condition and that the deceased needed further medical attention beyond history taking and physical examination. The instruction for blood test to be done on an urgent basis (refer page 55 'investigation' column) included full blood picture, renal profile, liver-function test, and urine test including pregnancy test and microscopic urine examination was also appropriate to investigate the condition of the patient. All these actions taken are in accordance with good neurological practice.

[21] In Q & A 15 p 7 D33, he added:

> The decision not to order a CT Scan at that point in time taking into consideration that the deceased's consciousness level was good, 14/15 as measured with the GCS scale and there were no abnormalities noted in the neurological examination. Her headache also appeared to have been relieved by the medication received at Klinik Bersatu. The right action at that point of time was to admit the patient and to put her under observation. There was no indication for a CT Scan to be ordered immediately at that point.

[22] On whether the fact that the deceased was drowsy or dizzy warranted a CT brain scan, Dr Johari Siregar replied in the negative and gave his reasons vide D33 p 8 Q & A 16:

> A CT scan was not immediately warranted taking into consideration that the deceased was given injection of Voltaren and that she had vomitting which could have caused the drowsiness and fatigueness. Furthermore, she was arousable meaning that she was still conscious and her GCS score was good with no obvious neurological deficits. She was also able to provide detailed response to several questions posted by the examining doctor. The decision to admit, observe,

investigate and start the deceased on infusion fluid was appropriate and in accordance with accepted neurological practice.

[23] Pertaining to the plaintiff's expert Dr Anil's disagreement that the deceased's GCS score of 14/15 was almost full because it was associated with drowsiness, Dr Johari Siregar explained that the score of 14/15 was almost full in the deceased's level of consciousness as her state of drowsiness could be due to the Volteran injection given to her at Klinik Bersatu which was intended to control her headache (D33 p 28 Q & A 55).

[24] It is undisputed fact that from exh D19 (bundle B at p 55) that at 4.30pm, upon examination of the deceased, Dr Suhaila found the deceased's GCS score to drop to 8/15 with pupils asymmetrical and sluggish reactive to light stimulus. She held the view that it could be intracranial bleeding and ordered CT scan to be done on an urgent basis to confirm or rule out her suspicion. According to Dr Johari Siregar, it is possible for GCS to drop suddenly from 14/15 to 8/15; GCS would not drop slowly and gradually and particularly in a case where there is SAH, it is common for GCS level to drop suddenly from 14/15 to 8/15 and even from 15/15 to 3/15 suddenly.

[25] The plaintiff through cross-examination of Dr Johari Siregar suggested that Dr Suhaila should not have waited until there was a significant drop of 6 points in the deceased's GCS score before she acted. Dr Johari Siregar nevertheless was of the opinion that basing on records which showed that a GCS test was done, intravenous infusion drips were given and baseline blood investigations were initiated, it indicated the fact that the deceased was not neglected and Dr Suhaila had recognised the patient's condition to warrant medical attention beyond history taking and physical examination.

[26] From the evidence recapitulated above in this respect and all the actions taken by Dr Suhaila from her first examination of the deceased at 2.15pm till before 4.30pm after the deceased's admission, observations and treatments as narrated in the preceding second issue, this court is of the view that it is incorrect from all available evidence to contend that Dr Suhaila had deliberately or negligently waited for the deceased's GCS score to drop from 14/15 to 8/15 before she acted to send the deceased for CT scan of the brain. Accepting Dr Johari Siregar's evidence that GCS score can drop suddenly and acutely but not gradually, the deceased's GCS score that dropped suddenly from 14/15 to 8/15 at 4.30pm could be a normal phenomena of a person having SAH. This court is of the view that such acute drop in GCS is beyond the control of Dr Suhaila or for that matter any doctor in her position since it just occurred suddenly with such acute drop. Evidence of Dr Anil indicated vividly that the deceased was still able to talk to plaintiff until about 5pm which means that the deceased's level of consciousness was or might still be good to be

able to talk rationally. This has in fact corroborated Dr Suhaila's report D20 that she had seen the deceased twice before 4.30pm, and found her GCS score to remain at 14/15. Had the deceased's GCS score dropped whether gradually or acutely before 4.30pm, it is unconceivable that the deceased would still able to consciously talk to the plaintiff until about 5pm. Anyway, there is no evidence from the plaintiff that the deceased's GCS score had dropped before 4.30pm. The unchallenged records and the evidence through Dr Anil of what the plaintiff had said in Dr Anil's expert opinion in exh P11 suggested that a reasonable inference can be drawn that there was no acute drop of the deceased's GCS score before 4.30pm in line with Dr Suhaila's version when the deceased was conscious to speak to the plaintiff.

[27] Looking at all evidence in this case and considering the constraint and limitation in Kepala Batas Hospital where there is no CT scan facility whereby any referral to CT scanning in another hospital required proper justification coupled with the fact that there was no abnormalities in the neurological examination of the deceased as noted by Dr Johari Siregar basing on available records tendered in court, this court finds that there might not be sufficient indication to warrant a CT scan earlier than 4.30pm especially when the vital symptoms of severe headache and vomitting of SAH were no longer the deceased's complaint upon her presentation at the Kepala Batas Hospital and there was no recurrence of such complaint. To this court, it would be ideal that the deceased had been sent for CT scan immediately upon admission but what is ideal may not be the reasonable action to be undertaken in a particular situation in the eyes of a reasonable competent or skilled doctor/medical officer. The question is whether it is reasonable for Dr Suhaila not to have so ordered in the circumstances of this case on all available facts upon her examination of the deceased and the outcome of the tests conducted by her? Having evaluated all evidence, I am inclined to accept the view of Dr Johari Siregar whose opinion was made after consideration of all available records, the circumstances and factors of the case with reasons and explanation as to how he arrived at his opinion that CT scan was not immediately warranted to that of Dr Anil who seemed to ignore the facts and circumstances or failed to take into consideration all the facts and circumstances and who had not supported his view with proper reasoning from the available facts of the case. I find that Dr Suhaila's act to be reasonable and the fact that she had not sent the deceased for CT scan earlier than 4.30pm was not an act of negligence in the circumstances as she had not neglected the deceased but had kept the deceased under close observation and for further investigation with various tests conducted to rule out or confirm the deceased's medical condition or diagnosis. I find from the facts of this case that that is the act of a reasonable doctor who is not a specialist nor a neurosurgeon.

Fourth issue: Whether there was any delay in sending the deceased to Seberang Jaya Hospital and to the Penang Hospital?

[28] One of the main complaint of the plaintiff was the delay in sending the

deceased for CT scan to Hospital Seberang Jaya, the failure to send the deceased straight from Hospital Seberang Jaya after CT scan to Hospital Pulau Pinang and the delay in sending the deceased from Kepala Batas Hospital to Hospital Pulau Pinang after returning from Hospital Seberang Jaya.

[29] The plaintiff also contended that SD7, the Director of Kepala Batas Hospital at the material time/by his letter dated 2 March 2007 (bundle B p 5–6) had admitted that there was engine failure and lack of petrol in the ambulance which led to the delay in sending the deceased to Hospital Pulau Pinang.

[30] Evidence showed that when the deceased's GCS score had dropped to 8/15 at 4.30pm, arrangement was made urgently for the deceased to be sent to the nearest hospital which has CT scan facility ie Seberang Jaya Hospital since Kepala Batas Hospital did not have that facility. Dr Nor Hafizah, SD2 gave evidence that she was called by Dr Suhaila at 4.53pm to accompany the deceased to Seberang Jaya Hospital for the CT scan. She arrived at Kepala Batas Hospital at about 5pm. Upon arrival, she examined the deceased and found her GCS to be 8/15. Although the deceased was unconscious, her blood pressure and pulse rate were stable and her oxygen saturation was 100%. SD2 then intubated the deceased to secure her airways. The intubation process was completed at about 6pm as SD2 had to prepare medication and equipment such as laryngoscope, syringes etc and two big cannula lines. Thereafter she had to prepare medication, equipment and relevant monitors to transport the patient; she had also to make arrangement for the nurse to accompany them. After intubation, SD2 would have to ensure that the tubes entered the correct cavity by examining the lungs and sound of gas in the deceased's stomach. She also had to direct the medical assistant and the nurse to fix the Ryle's tube and urine catheter and she had to check the vital statistics of the deceased. After this medical process, the deceased was placed in the ambulance which left Kepala Batas Hospital at 6.40pm. The log book for ambulance WKK 2416, D26 and the evidence of its driver, SD4 confirmed the time of departure. The defendants submitted that taking into account the time required for the intubation process, there was no delay in sending the deceased to Seberang Jaya Hospital relying on the evidence of Dr Johari Siregar who said that the time taken was reasonable because the intubation was not easy in this case. He added that although on average, it took about an hour for a patient to be transported to the referral centre for CT scan, this can be longer if the patient was not stable; stability of the patient needs to be prioritised. Intubation was necessary to ensure the patient had a stable and safe journey to Seberang Jaya Hospital. The plaintiff seems to suggest that no intubation was necessary when cross-examining Dr Johari Siregar but that was refuted as stability of the patient along the journey was an inevitable process. However, there is no evidence nor explanation from the plaintiff or his expert witness as to why such process was

unnecessary or any evidence that the time taken for the intubation and other preparation to ensure the stability and safety of the deceased along the journey to Seberang Jaya Hospital was unreasonable. Evidence of the defence as to the reasonable time taken to prepare the deceased for the said journey was not rebutted nor successfully challenged and must therefore be accepted as the reasonable time in the instant case; see *International Times & Ors v Leong Ho Yuen* [1980] 2 MLJ 86 (FC). On a balance of probabilities, this court finds no evidence of any undue delay to send the deceased from Kepala Batas Hospital to Seberang Jaya Hospital.

[31] At Seberang Jaya Hospital, CT scan was carried out at 6.55pm and the result showed a large right frontal bleed, SAH, bleeding into ventricles and a midline shift of the brain. SD2 had duly informed Dr Suhaila of the said result and was informed by Dr Suhaila that she had called up several hospitals in Penang, Alor Setar, Sungai Petani and Ipoh but there was no ventilator available in all those hospitals as well as in Seberang Jaya Hospital. Since a referral hospital had not been identified, SD2 made the decision to return to Kepala Batas Hospital which had the required equipment and medication while awaiting decision as to the referral hospital. They arrived at Kepala Batas Hospital at 7.40pm. In this respect, Dr Johari Siregar, being the National Head of Neurosurgery under the Ministry of Health, stated that although Penang Hospital had both CT scan facility and a Neurosurgery Department, the deceased could not have been sent straight there because the Neurosurgery Department at Penang Hospital, being the receiving hospital, would need the CT scan findings in order to decide whether or not to accept the referral. CT scan finding is also needed for consultation purpose. Dr Johari Siregar stressed that for the purpose of diagnosis of the deceased's medical condition, she was correctly sent to Seberang Jaya which is nearer than Penang Hospital. When it was uncertain of the availability of a ventilator which was required by the deceased under that condition and no decision from Penang Hospital for the deceased to be referred to after the CT scan at Seberang Jaya Hospital, the decision to bring the deceased back to Kepala Batas Hospital was correct. At the material time, the deceased needed ICU facilities with ventilators available but they were not available then at Penang Hospital; the deceased could not be sent straight away to Penang Hospital when Penang Hospital was yet to give its approval. Penang Hospital gave its approval at 8.45pm and the deceased was immediately sent after the necessary preparation at 9.29pm.

[32] From the evidence above recapitulated, it is undoubted that there are constraints and limitations for which Dr Nor Hafizah (SD2) could not send the deceased directly from Seberang Jaya Hospital after the CT scan to Penang Hospital as there was no ICU beds and ventilators available at the Penang Hospital as well as no approval was given yet at that time. There is, to this court, nothing that either Dr Nor Hafizah or Dr Suhaila could do except to wait for

the green light from the receiving hospital. It is inappropriate to attach blame on Dr Nor Hafizah since her hands are tied having to comply with the requisite medical procedures in public hospitals nor could she be blamed also for sending the deceased back to Kepala Batas Hospital where there are proper and better facilities for the deceased as compared to Seberang Jaya Hospital for the benefit of the deceased while waiting for the approval of the receiving hospital. It is not a situation where approval had been granted and yet Dr Nor Hafizah still decided otherwise by sending the deceased back to Kepala Batas Hospital knowing that Penang Hospital had given its approval to receive the deceased. In the circumstances, I find that Dr Nor Hafizah's decision to send the deceased back to Kepala Batas Hospital to be reasonable in the circumstances. It must be noted that Dr Nor Hafizah and the deceased arrived back at Kepala Batas Hospital at 7.40pm and approval from Penang Hospital was given at 8.45pm and the deceased was immediately sent after the preparations at 9.29pm. On a balance of probabilities, I hold that there is no merit in putting the blame on the defendants for not sending the deceased directly from Seberang Jaya Hospital when there was no approval from Penang Hospital, being the receiving hospital, to do so. The medical officers cannot be faulted for complying with the rules and procedure or standard practice laid down by and enforceable in the public hospitals. Policy consideration is for the authority. If there are bad policies, rules or procedures or standard practice, it is for the public to bring to the attention of the authority to change them. Otherwise, so long as the policies, rules or procedures or standard practice remain valid and enforceable, any doctors in the public hospitals are bound to comply with them. It will be unjust for the court to hold doctors negligent or breach of their duties of care to the patients for complying with the policies, rules or procedures or standard practice which they are duty bound to follow.

[33] On the plaintiff's allegation of delay in sending the deceased from Kepala Batas Hospital to Penang Hospital after her return from CT scan at Seberang Jaya Hospital, to reiterate, although the deceased had arrived at Kepala Batas Hospital at 7.40pm, she could not be sent to Penang Hospital when there was no approval to do so from Penang Hospital. This appears to be the standard procedure. Approval was granted at 8.45pm; Dr Nor Hafiza received instruction from Dr Suhaila at 8.50pm to accompany the deceased and after the necessary preparations, the deceased was sent at 9.29pm. In my view, the time taken to prepare the deceased for transportation from Kepala Batas Hospital to Penang Hospital in about 45 minutes bearing in mind that the deceased had to be stabilised, cannot be said to be unreasonable as to be construed as a delay. In any event, there is no contrary evidence from the plaintiff to indicate the probable time taken could be a shorter time or that 45 minutes was unreasonably long time to prepare the deceased under that condition which Dr Johari Siregar was of the view that it was reasonable on ground that the deceased must be stabilised before she could be transferred to

another hospital. Therefore, I am inclined to hold, upon finding of facts, that there was no delay on a balance of probabilities.

[34] Pertaining to the plaintiff's contention that there is admission by SD7, the Director of Kepala Batas Hospital at the relevant time, vide his letter dated 2 March 2007, of faulty engine and lack of petrol in the ambulance which constituted the delay, SD7 had denied that there is any admission of faulty engine of the ambulance or the lack of petrol in the ambulance which necessitated filling of petrol thereby causing the delay to send the deceased from Kepala Batas Hospital to Penang Hospital. SD7 explained that the contents of the said letter were the general view in relation to treatment and ambulance service provided by the hospital. On para 3 of the letter regarding 'kekurangan yang dikenal pasti,' after a comprehensive investigation had been carried out on the plaintiff's complaint that there was a lack of petrol in respect of the ambulance which was supposed to send the deceased to the Penang Hospital, SD7 said that whether there was lack of petrol or not, improvement measures had to be taken to ensure better and smooth operation which was common after every investigation. By doing so, it did not mean the existence of negligence but it was a general procedure flowing from an investigation. The improvement measure was in relation to work process such as a proper documentation when the ambulance driver was required to sign on the log book before going out to fill petrol. He explained further that the word 'kekurangan' in the third paragraph in the letter did not refer to lack of petrol or the failure to treat patient but the sufficiency of administration. Reading the contents of this said letter, I must agree that nowhere did it admit categorically that there was a lack of petrol in the ambulance on 10 October 2006 resulting in the delay in sending the deceased to Penang Hospital nor that the attending doctors had failed to provide treatment to the deceased. The letter was couched more in general term as to the improvement measures undertaken by the hospital. I find no admission of any fault or negligence as contended by the plaintiff.

[35] The plaintiff's complaint of the delay by the ambulance because it had gone out to fill petrol when it was supposed to send the deceased to Penang Hospital, was based on Dr Suhaila's report, exh D20 at bundle E p 13 para No 11 where Dr Suhaila stated that when plaintiff asked about the delay by the ambulance, she had asked her staff and was informed that the ambulance had gone out to fill petrol and she informed the plaintiff on what she was told. That was the plaintiff's basis in his allegation. However, the plaintiff failed to heed Dr Suhaila's explanation in the same page at para No 13 where she said she thereafter knew that the ambulance which was to bring the deceased was ready and it was not the ambulance that had gone out to fill petrol. SD2 Dr Nor Hafizah who accompanied the deceased in the ambulance to Penang said that there was no problem of the ambulance which was to take the deceased to

Penang Hospital. Similarly, SD5, the assistant medical officer who was in charge of ambulances at the relevant time and the ambulance driver SD6 also gave evidence that there was no problem of the ambulance which was to send the deceased to the Penang Hospital. SD6 said he drove ambulance No WGD 5094 from Kepala Batas Hospital to Penang Hospital after receiving instruction from SD5 at 9.15pm and left for Penang Hospital at 9.29pm and this fact was unchallenged. There was also no evidence of any faulty engine with the ambulance except the mere allegation by the plaintiff. The plaintiff attempted to rely on his secretly tape-recorded conversation between himself and SD7, the Director of Kepala Batas Hospital then, the transcript of which was produced as P5. SD7 was extensively cross-examined on this but he was able to explain what he meant logically. I find that the conversation of SD7 that was tape-recorded was non-committal to mean any form of admission of the faulty ambulance engine or the lack of petrol in the ambulance.

[36] The defence had also tendered the report by an Independent Investigation Committee established by the Penang Health Department to investigate the plaintiff's complaint in this aspect (D21 and D21A) and its finding is that there was no faulty ambulance as complained by the plaintiff (see bundle E p 37).

[37] From the evidence as a whole and on a balance of probabilities, I do not find that the plaintiff had proved his allegation of the faulty engine of the ambulance or the lack of petrol in the ambulance that caused the delay in sending the deceased from Kepala Batas Hospital to Penang Hospital. Evidence from SD6 that he received instruction at 9.15pm and left Kepala Batas Hospital at 9.29pm with the deceased for Penang Hospital in 14 minutes in ambulance WGD 5094 cannot be construed as a delay.

Fifth issue: Whether in evaluating the evidence of both experts SP2 and SD8, which are apparently conflicting, which body of opinion that the court would prefer

[38] In determining matters of diagnosis and treatment being carried out on patients, the court will generally rely on the evidence of expert witnesses: *Sidaway v Bethlem Royal Hospital Governors and others* [1985] 1 All ER 643. This is for simple reasons that judges are non-doctors or medical specialists.

[39] In *Hucks v Cole* [1993] 4 Med LR 393, when determining a doctor's liability in a given case, it was held that it was appropriate for judges to reject medical expert evidence if they do not really stand up to analysis.

[40] In *Maynard v West Midlands Regional Health Authority* [1985] 1 All ER 635, the House of Lords held as follows:

Where a plaintiff's claim was based on an allegation that the fully considered decision of two consultants in the field of their special skill was negligent, it was not sufficient for the plaintiff to show that there was a body of competent opinion which considered that that decision was wrong if there also existed a body of professional opinion, equally competent, which supported the decision as being reasonable in the circumstances. Furthermore, it was not sufficient for the plaintiff to show that subsequent events demonstrated that an operation need not have been performed if the decision to operate was reasonable at the time, in the sense that a responsible body of medical opinion would have accepted it as being proper. It had to be recognised that differences of opinion and practice existed in the medical profession and that there was seldom any one answer exclusive of all others to problems of professional judgment and therefore although the court might prefer one body of opinion to the other that was not a basis for a conclusion that there had been negligence on the part of the defendant doctor ...

[41] The defendants submitted that it is trite law that the foundation which a court accepts the evidence of an expert witness is based on his credibility. On the plaintiff's expert witness, SP2, the defendant submitted that he is not a credible witness and his evidence ought to be rejected or viewed with caution and suspicion relying on the following reasons which SP2 admitted in cross-examination:

(a) there were two allegations of sexual harassment and misconduct against SP2 while he was undergoing neurosurgical training in the United Kingdom and he was suspended while investigations were carried out;

(b) the General Medical Council (GMC), the body which regulates doctors in the UK, had received numerous complaints against SP2. However, the GMC could not proceed with any action against him as he had returned to Malaysia;

(c) SP2 claimed that he was a senior consultant neurosurgeon at Grade U54 at Hospital Ipoh while he was still in public service before leaving for private practice in 2006.

[42] From a circular D35 issued by the Ministry of Heath, to be a consultant neurosturgeon, one must have been a specialist for five years and to be a senior consultant neurosurgeon, one must be a specialist for at least ten years. SP2 agreed that he came back to Malaysia from the UK in 2002; he was gazetted as a specialist in 2004 and he resigned in 2006 from public service. He thus had less than five years as a specialist and could not be qualified as a consultant when he was working at the Ipoh Hospital, leave alone a senior consultant neurosurgeon at Ipoh Hospital.

[43] SD8, the defendants' expert witness who was the National Head for Neurosurgery at the material time and still is, tendered as exh D35 the relevant circular which laid down specifically the requirements for one to be approved and designated as clinical specialist neurosurgery (completed neurosurgery training successfully), specialist neurosurgeon (five years working experience), consultant neurosurgeon (between 5–10 years working experience) and senior consultant neurosurgeon (more than 10 years working experience). Basing on the circular D35, SD8 said that SP2 was gazetted as a specialist neurosurgeon in February 2004 and was never given the designation as a consultant neurosurgeon. SP2's working experience as a specialist neurosurgeon was less than five years; he could not have qualified for the position as a consultant neurosurgeon nor be qualified to be designated as a senior consultant neurosurgeon. SD8 added in his evidence that he had inquired from Ipoh Hospital and was informed that SP2 had resigned from government service in April 2006 at the grade of U48 and was not at grade U54 and resigned in 2005 as claimed by SD2.

[44] From the above grounds as submitted by the defendants, I am of the view that the fact that SP2 had some past misconduct itself does not make him a non-credible witness. In any event, those misconduct and/or complaints were not pursued nor proven and cannot be the basis for contending that SP2 is not a credible witness. It must be borne in mind that even with those alleged past misconduct or numerous complaints SP2 was absorbed and gazetted as a specialist in neurosurgery in the government hospital. If those were the material criteria and pertinent factors to be considered, then there is no rationale for him to be accepted as a specialist in the government hospital. However, on SP2's designation which he claimed he was a senior consultant neurosurgeon at the grade of U54 when he was working in Ipoh Hospital before he resigned in the year 2005, it is probable that SP2 may be mistaken of the year 2005 for 2006 when he said so and this court is prepared to give him the benefit of the doubt but to claim that he was a senior consultant neurosurgeon with less than five years working experience as a specialist in direct conflict with the Ministry's Circular, D35, which categorically listed out the number of years of working experience for one to be designated as senior consultant neurosurgeon ie of more than ten years, such an assertion cannot be a mistake but an untruth which might not be detected if not of the Circular D35 and the evidence of SP8, the National Head of Neurosurgery. In addition, I do not think that it could be a mistake for SP2 to affirmatively said that he was holding grade U54 and resigned when he was at that grade when in actual fact, he was holding a lower grade at U48. After all SP2 had only resigned once from government service and it is improbable that he could make such a glaring mistake in the last grade that he held before he resigned. By being untruthful in his evidence as to his last designation in the government hospital and the grade he held before he resigned, I am inclined to agree with the defendants' submission that SP2 is not a reliable witness and as a matter prudence, the

court must scrutinised the rest of his evidence with great care and suspicious; see *Khoon Chye Hin v Public Prosecutor* [1961] MLJ 105 (CA). Another point raised by the defence which affects SP2 credibility is his allegation that his application to rejoin the service was accepted but his request for the post of paediatric neurosurgeon was rejected. SD8 who was asked by the Director of the Professional Division of the Ministry of Health to provide them with the recommendation as to SP2's application as a paediatric neurosurgeon with special grade said in evidence that SP2's application was discussed in the Heads of Department meeting chaired by him with the presence of all the seven Heads of the Ministry of Health Neurological Centres in the country (except Sarawak) held in KL Hospital on 19 December 2007 and, it was the unanimous decision to recommend to the Director General of Health to reject SP2's application to rejoin service on ground that he was not qualified by reason of his unsatisfactory clinical competency, technical judgment and adherence to medical staff bylaw during his previous affiliation with the Ministry of Health organisation. With this fact adduced by SD8 who was the National Head directly involved in SP2's application to rejoin the service, it shows another untruth being told by SP2. This court finds no reason that SP2 should lie to the court except to attempt to enhance his position that he was already holding the senior consultant neurosurgeon position at a high grade U54 when he resigned and when he applied to rejoin service, his application was even accepted but that the Ministry declined to accept his request for the post of Pediatric Neurosurgeon that he did not rejoin the service. If that was his intention, I must say it back fires and it only goes to show how untruthful a witness he is.

[45] As to the expertise of SP2, he admitted in cross-examination that for the last two years preceding this trial, he did not operate on patients; he merely did some minor procedure only. The defendants thus submitted that this does not make him a fit and proper person to give expert evidence on neurosurgery.

[46] In *Folkes v Chadd* (1782) 3 Doug KB 157, Lord Mansfield said that: 'The opinion of scientific men upon proven facts may be given by men of science within their own science.' The important determination is as Lord Russell posed in *The Queen v Silverlock* [1894] 2 QB 766, 'The question is — is he peritus; is he skilled, has he adequate knowledge?' Experience or working experience is an important aspect of an expert which will lead to show whether he has sufficient knowledge and skill in the field he professes himself to be an expert. An expert witness is required to adduce evidence of his working experience besides his qualification and the fact whether he had testified in court before and whether if he did, his evidence had been accepted by the court: *Wong Chop Saow v Public Prosecutor* [1965] 1 MLJ 247. The fact as submitted that SP2 only did minor procedure but had not undertaken neurosurgical operation for the past two years only goes to show his lack of practice but it may

not necessarily disqualify him to be an expert witness when he had undergone the necessary training to be a neurosurgeon and had worked as a neurosurgeon at Ipoh Hospital from 2002–2005 before he resigned. If he has adequate knowledge, he can be an expert. SP2, however, is certainly less experienced and less exposed to hands on work in neurosurgery as compared to SD8 who is of vast working experience in the neurosurgery field and also as the Head of the Neurosurgery Department at the Sultanah Aminah Hospital Johore Bahru which is the main centre of neurosurgery in the country. After having seen and heard both SP2 and SD8, this court must say that SD8 is undoubtedly more qualified and comprehensive in term of practical experience as well as his knowledge in matters of neurosurgery than SP2.

[47] Another point raised by the defence in submission is that SP2 in cross-examination asserted he could not read the examination and treatment notes in the handwriting of Dr Suhaila at pp 48 and 55 bundle B (exh D19) but during re-examination, he was able to read or decipher them without difficulty. I must agree that the demeanor of SP2 in this respect created a doubt in his evidence that he is an impartial witness. Further to the defence's submission on the above points, one very vital matter that this court can see from SP2's evidence is that he had failed to consider in totality all relevant factors which Dr Suhaila had found upon her examination of the deceased at the Kepala Batas Hospital ie the fact that the deceased was no longer complaining of severe headache but dizziness with abdominal pain; there was no vomitting; the deceased was given injection of Volteran at Klinik Bersatu which, according to Dr Johari Sfregar (SD8), might have caused the deceased's dizziness; the deceased's pupils were symmetrical and she was able to move all her limbs; as well as the fact that even the deceased was able to speak to the plaintiff until 5pm. In short, all these factors did not indicate that the deceased was having SAH at the time of examination and admission of the deceased for further observation. SP2 dearly was relying only on the history as stated in the referral letter of Klinik Bersatu and deliberately ignoring all the aforesaid relevant and material factors. This court notes that even with the existence of the alleged symptoms of SAH, the general practitioner at Klinik Bersatu did not even state that the deceased was probably suffering from SAH or intracerebral bleed or that the deceased was suspected of having those conditions. Hence, when the symptoms of SAH were no longer complained of when the deceased was examined by Dr Suhaila, it is only probable and reasonable that Dr Suhaila did not confirm the medical problem but endorsing the probable seriousness of the deceased's condition, she admitted the deceased for further observation and investigation with the view of perhaps achieving a proper diagnosis, treatment and action. In this respect, I am prepared to accept Dr Johari Siregar's view to that of Dr Anil as Dr Johari Siregar had taken into consideration all those relevant factors before he gave his view whereas Dr Anil had never even mentioned any of those relevant factors least to mention to have considered them. This court must draw the necessary reasonable inference that Dr Anil

had failed to consider them before concluding that there is negligence on the part of Dr Suhaila. Dr Anil had in addition taken into account unproven facts such as ambulance engine failure, delay in transporting the deceased from Kepala Batas to Penang, new ambulance provided but with no petrol and delay in filling petrol. From the evidence before this court, it has been established that there is no issue of ambulance engine failure nor the question of no petrol or the delay in filling petrol. The fact that Dr Nor Hafizah (SD2) took about 45 minutes after obtaining the approval to send the deceased to the Penang Hospital to intubate the deceased, to do other necessary preparations before leaving for Penang Hospital which Dr Johari Siregar opioned to be reasonable as the patient had to be stabilised so that she would have a safe journey to Penang Hospital, was also not considered by SP2; perhaps he was not appraised with such fact. This court accepts the evidence of Dr Nor Hafizah and Dr Johari Siregar that the time is reasonable in the circumstances and the time taken of 45 minutes is not undue delay. Dr Anil had also failed to take into account the constraint and limitation encountered by Dr Suhaila as she had to obtain approval in advance from the receiving hospital before she could direct the deceased to be sent to Penang Hospital accordingly. Approval in this case was only given at 8.45pm and the deceased was sent in the ambulance which left at 9.29pm. This court is of the view that the failure to take into account the constraint or limitation in the resources and procedures in the Kepala Batas Hospital and the consideration of irrelevant matters would have affected adversely the opinion of SP2 which this court finds to be doubtful and suspicious whether it was a fair opinion or one which is bias. Dr Anil in his report P11 had also taken into consideration facts which were non-existence at the material time as in his conclusion that the deceased was in drowsy confused state when evidence showed that she was lightly drowsy or sleepy but reusable; there is absolutely no evidence that the deceased was in a confused state. The plaintiff did not even say so. The plaintiff said that the deceased was able to speak to him till about 5pm that day. Dr Anil did not explain how he gathered this fact that the deceased was in a confused state against all available evidence. He also alleged that time was being wasted when the deceased was sent in a critically unstable state with a junior doctor or nurse for a CT scan to Seberang Jaya Hospital. This court cannot find any evidence which goes to support this allegation. Evidence shows that Dr Nor Hafizah is a medical officer; she intubated the deceased to stabilise her as well as used manual ventilator on the deceased when sending the deceased to Seberang Jaya Hospital. There is no evidence that anything had gone wrong while the deceased was transported in the ambulance. This conclusion of Dr Anil, to this court, is clearly unsubstantiated. His further conclusion that the attending doctor did not pick up the history as mentioned in the referral letter of Klinik Bersatu constitutes gross medical negligence is against the weight of the evidence which shows unequivocally that all the relevant symptoms of severe headache with vomitting, recurrent headache that were stated by Dr Anil were no longer present nor complained of at the time of the deceased's presentation at Kepala

A B C D E F G H I

Batas Hospital and at the time of the examination by Dr Suhaila. This conclusion which allegedly contributed towards his conclusion of gross medical negligence again is unsupported by clear evidence nor was it a considered opinion since the relevant factors and facts which are favourable to the defence were not considered at all by Dr Anil nor did he give an reasonable explanation as to why all these factors or material facts were disregarded by him. His opinion or conclusion, in such situation, cannot be construed as a proper and fair one taking into account all relevant facts but one which is tilted in favour of the plaintiff by disregarding all relevant and material facts of the case which were available to him.

[48] Dr Johari Siregar, SD8, the expert for the defence, besides being a better qualified and experienced person as senior consultant neurosurgeon, Head of Department of Neurosurgery at Hospital Sultanah Aminah Johor Bahru and National Head of Surgery since 2001 till the date of trial, had given evidence as to his views, opinions based on all relevant facts and circumstances of the case and supported his views or opinions with reasonable explanations and with relevant medical literatures (D32) where necessary. On the plaintiff's challenge as to Dr Johari Siregar's annual practising certificate, I find such contention insignificant and lame as Dr Johari Siregar has been working with the government service from 1984 till todate. I accept his record of service tendered as D33 as proof of Dr Johari Siregar's expertise and working experience in the public hospital in the field of neurosurgery without breach and that he is an expert in that field. In *Singapore Finance Ltd v Lim Kah Ngam (S'pore) Pte Ltd & Eugene HL Chan Associates (third party)* [1984] 2 MLJ 202, it was held, inter alia, that:

> Held:
>
> (3) the court's approach in evaluating the conflicting expert's evidence is to examine the scientific grounds and bases, on which they rely. Where the opinion of an expert is based on reports of facts and empirical observations, the court has to satisfy itself, on a balance of probabilities, whether those facts did in truth exist and whether any inference or inferences drawn from those facts taken individually or collectively, were sound or not.

[49] From Dr Johari Siregar's expert report D34, his witness statement and his oral evidence, he analysed all the medical records from the treatment notes of Dr Suhaila and all investigations that had been carried out; he gave detailed accounts and explanations of the medical condition of the deceased initially and after CT scan; he explained the causes of SAH and, the fact that severe headache itself may not necessarily lead to SAH as the percentage is very low according to medical literature. On the GCS score he said it could drop rapidly from 14/15 to 8/15 all of a sudden and it may not drop gradually. He outlined the non-feasibility of a direct transport from Kepala Batas Hospital or from

Seberang Jaya Hospital to Penang Hospital due to the lack of intensive care resources and suggested how to handle such situation. On account of lack of multidisplinary support particularly the critical care units, transfer to major hospitals was difficult and time consuming. He looked into the cause of death of the deceased, the diagnosis of SAH which is a rare occurrence, the clinical progress undertaken by Dr Suhaila and on the advice of the Specialist Dr Kamil, the outcome of patient with cerebral aneurysm and the prospect of patient surviving as well as the care practice undertaken due to constraints such as lack of neurosurgeons and unavailability of technology like CT scan facilities or angiogram facilities. He looked into all material facts when he gave his view or opinion. He withstood extensive cross-examination. I find Dr Johari Siregar's evidence to be cogent, reasonable, logical and most of all that his views or opinions are supported by material facts or by medical literatures and hence they are sound.

[50] Having evaluated very carefully the evidence of Dr Anil and Dr Johari Siregar, I am satisfied that on a balance of probabilities, Dr Johari Siregar's views or opinions are to be preferred to the views or opinions of Dr Anil which comparatively are unsupported by material facts or medical literatures or wrong interpretation of medical literature. This is coupled with the facts that this court also doubts Dr Anil's credibility when it has been proved that he was untruthful as discussed above. Having so held, it must be said that it is trite that it is not the expert who determines whether a party is negligent or not but the ultimate decision is on the court. The expert's opinion in the medical science is relevant to assist the court to come to a just finding.

[51] Taking into consideration the expert opinions of Dr Johari Siregar and evaluating them in the light of the evidence of both parties in this case, I find that the action taken by Dr Suhaila in the circumstances of this case to be reasonable of a skilled or competent medical officer and that she was not negligent nor was she in breach of her duty of care to the deceased. Similarly, bearing in mind the constraints and the available resources at the Kepala Batas Hospital, it is only reasonable that time would be consumed to make all necessary arrangements after having obtained the necessary approvals before the deceased could be sent to Seberang Jaya Hospital for CT scan and ultimately to Penang Hospital for neurosurgery treatment. Time could have been improved or shortened which is most ideal but the fact that a patient required a slightly longer hour than another does not necessarily signify negligence when evidence shows that necessary actions have indeed been taken bearing in mind all the constraints and limitation that have existed which are due to no fault of the parties involved.

Sixth issues: Whether the plaintiff has proved causation ie whether it was the alleged delay, if any, that caused the death of the deceased

[52] The defendants submitted that the burden is on the plaintiff to prove

that the death of the deceased was caused by the alleged delay in the treatment of the deceased at Kepala Batas Hospital citing in support the House of Lords cases of *Hotson v East Berkshire Area Health Authority* [1987] AC 750; *Wilsher v Essex Area Health Authority* [1988] 1 All ER 871; the Malaysian cases of *Udhaya Kumar a/l Karuppusamy & Anor v Penguasa Hospital Daerah Pontian & Ors* [2004] 2 MLJ 661; *Dominic Puthucheary & Ors (personal representatives of the estate of Thayalan a/l Kanapathipillai) v Dr Goon Siew Fong & Anor* [2007] 5 MLJ 552; [2007] 5 CLJ 38 (CA); *Dr KS Sivananthan v The Government of Malaysia & Anor* [2001] 1 MLJ 35; *Payremalu a/l Veerappan v Dr Amarjeet Kaur & Ors* [2001] 3 MLJ 725 and *Hassan bin Datolah v Kerajaan Malaysia* [2003] 2 MLJ 425, all of which held that there must be a causal link between the injury (or death as in this case) and the delay in treatment or negligent act or conduct of the health authority and the burden is on the plaintiff to prove them on a balance of probabilities.

[53] It is the defendants' contention that the cause of death of the deceased is subarachnoid haemorrhage (bleeding in the brain) caused by Ruptured Cerebral Aneurysm (a swelling that looks like a small balloon in the wall of one or more of the blood vessels in the brain) as determined by Dr Johari Siregar vide his medical opinion D34 and it was not due to any negligence of the servants and agents of the defendants. From the CT scan carried out on the deceased at Seberang Jaya Hospital, it revealed bleeding in the subarachnoid space of the brain or subarachnoid bleeding, bleeding in the right frontal lobe of the brain or right frontal intracerebral clots; bleeding in the vertical systems of the brain or intraventricular clots; brain odema or swelling with midline shift and hydrocephalus indicating building up of the normal fluid that bathes the brain, inside the brain causing the cavities (ventriles) inside the brain to enlarge; D34 and D33 Q & A.26 are referred. In short, by looking at the CT scan films (D22), Dr Johari Siregar summarised that the deceased had bleeding on the surface of her brain, the brain itself and in the deep cavity of the brain. Explaining further from the films, Dr Johari Siregar said that the bleeding was located in the space in the brain called subarachnoid. SAH was seen at the base extending over the surface of the brain. The bleed in the brain called intra cerebral haemorrhage was located in the front part of the brain called frontal lobe. The diameter of the intra cerebral haemorrhage was 4mm and was present in most of the two-third of the frontal lobe resulting in the swelling of the brain, blockage of the deep water system of the brain known as hydrocephalus and the brain was signify from right compartment to the left and from the upside compartment to the downside compartment. From these scan findings, Dr Johari Siregar stated that the deceased had suffered from massive multiple bleeding. This explained the deceased had sudden loss of consciousness, the sudden drop in GCS score from 14/15 at 2.15pm to 8/15 at 4.30pm and her pupils changed from symmetrical at the first examination to asymmetrical at 4.30pm when the deceased's condition deteriorated. After CT scan, it was confirmed that the deceased suffered from SAH most probably caused by

ruptured cerebral aneurysm since there was no history of head trauma. Dr Johari Siregar explained that cerebral aneurysm is a weak area in a blood vessel that usually enlarges or ballons out of the blood vessel; the weakness in the blood vessels is usually congenital ie due to birth defect (referred D33 Q & A 31) or hereditary or due to diseases or injection of the blood vessel. The occurrence of SAH in our country, according to him is rare. He cited the statistics that in Johor Bahru which is the centre for treating patients with this condition, only 8% to 10% of such condition are seen among 10,000 cases that he and his team have treated annually. Because of the scarcity of this condition, medical practitioners have difficulty in diagnosing the condition as they are not exposed or may have limited exposure to the condition during their training or while they are practising.

[54] When the deceased was ultimately sent to Penang Hospital arriving at 10.20pm 10 October 2006, the doctor at the Neurological Department diagnosed that she had brain death and did not perform any surgical intervention but advised that the deceased be treated conservatively. The question is: what are the chances of survival of the deceased if she were to be operated when she arrived at the Neurological Department, Penang Hospital? Dr Johari Siregar answered that the chances of survival if she were to be operated would be 10% since the severity of her SAH was of Grade 5. The CT scan findings had confirmed the presence of a very severe and irreversible injury to the brain. This coupled with the rapid clinical deterioration from the time of her admission (GCS 14/15 with symmetrical and reactive pupils) to before transferring to Hospital Seberang Jaya (GCS 8/15 with asymmetrical pupils), after coming back from Hospital Seberang Jaya (GCS 4+T/15) and when she arrived at Penang Hospital (GCS 2 +T/15 with asymmetrical (6mm) and non-reactive pupils), indicated that the deceased was likely to die even with aggressive medical or surgical treatment and any further treatment or procedure at Penang Hospital would be deemed untruthful and thus unnecessary. With the deceased suffering from irreversible extensive damage to the brain, thus, even if she was sent straight to Penang Hospital from Seberang Jaya Hospital, according to Dr Johari Siregar, her outcome would not have been any different. This is because her mortality rate if she were to be sent directly from Seberang Jaya Hospital to Penang Hospital was almost 100% as the deceased was already dependent on mechanical ventilator support for breathing. Dr Johari Siregar is of the opinion that on account of the problems of rarity and wide spectrum of presentation and experience, the suspicion index of the patient's condition was low. When she deteriorated at 4.30pm, CT scan was ordered which confirmed that she had massive bleed. This together with her poor clinical grade indicates that the deceased would not survive irrespective whether she was given any medical or surgical treatments. On the cross-examination that the confirmation of SAH was late when nothing could be done, Dr Johari Siregar replied that the confirmation of diagnosis of SAH was done timely, ie when the index for clinical suspicious was clear. He

disagreed that surgery should have been done before the deceased's GCS dropped to 8/15 explaining that surgery was not possible as the diagnosis was only confirmed at 6.55pm and that the deceased would have to undergo another investigation (angiogram) to confirm the presence of aneurysm before surgery could be considered. Only upon confirmation of SAH and aneurysm as the cause as well as the clinical condition of the patient being stable that surgery could be carried out. Dr Johari Siregar added that the deterioration in GCS was not conclusive that the patient had SAH; it is merely indicative for a CT scan. In the deceased's case, the index of suspicion of SAH was clear at 4.30pm and that was indicative for CT scan to be done to confirm such suspicion. From the results of the CT scan at 6.55pm, the patient was impending coning which is downward descend of the brain. The signs for this are the deceased's low GCS score, her eye size being asymmetrical and her dependence on ventilator. According to Dr Johari Siregar, coning means that there was a severe herniation of the brain and this is associated with almost 100% mortality. Impending coning signifies the presence of a deadly side effect of intracranial pressure and indicates a fatal outcome; coning leads to brain death; the treatment would be conservative as in that condition, surgery should not be considered because the patient would not be able to take surgical intervention. Dr Johari Siregar maintained that after the CT scan and its results, the deceased would not have survived. He further maintained that upon the deceased's first presentation at the Kepala Batas Hospital on 10 October 2006 at 1.55pm, her complaint was only dizziness and neurological examination showed normal findings of GCS score at 14/15, pupils reactive and symmetrical. Hence, the index of suspicion of SAH was very low until 4.30pm when the neurological symptoms of SAH emerged with GCS score dropping to 8/15 and her pupils becoming asymmetrical. Dr Suhaila recognised and suspected intracranial bleeding as noted by her in D19 p 55 bundle B which warranted CT scan and it was done at 6.55pm at Hospital Seberang Jaya.

[55] Basing on the evidence of Dr Johari Siregar, the defendants submitted that the outcome of the deceased was not caused by any negligence on the part of the defendants but caused entirely by SAH that she suffered possibly due to a ruptured of cerebral aneurysm and that no causation had been proved by the plaintiff that the death of the deceased was caused by the servants and agents of the defendants citing in support cases of *Barnett v Chelsea and Kensington Hospital Management Committee* [1969] 1 QB 428 and *Lechemanavasagar a/l S Karuppiah v Dr Thomas Yau Pak Chenk & Anor* [2008] 1 MLJ 115; [2008] 3 CLJ 76.

[56] In *Barnett*'s case, the fact showed that three night-watchmen presented themselves at the defendants' hospital complaining to a nurse on duty that they had been vomitting after drinking tea. The nurse reported their complaints by telephone to the duty medical casualty officer who instructed her to tell the

men to go home to bed and call in their own doctors. The men then left and about five hours later, one of them died from poisoning by arsenic which had been introduced into the tea; he might have died from the poisoning even if he had been admitted to the hospital wards and treated with all care five hours before his death. In holding that the defendants owed the deceased watchman a duty to exercise the skill and care to be expected of a nurse and medical casualty officer and the medical casualty officer was held negligent in not seeing and examining the deceased admitting and treating him thereby breaching their duty to the deceased, the plaintiff's claim nevertheless failed because the deceased must have died of the poisoning even if he had been admitted to the wards five hours before his death and treated with all care and the plaintiff had failed to establish that on a balance of probabilities that the defendants' negligence had caused the death.

[57] In *Lechemanavasagar*'s case, the plaintiff had accidentally swallowed a fishbone. He saw the first defendant, an ENT specialist. An operation was performed to remove the fishbone. He was supposedly put on 'nil orally' after the operation but was given tablets orally and a drink of Milo by the nursing staff of the hospital. The plaintiff subsequently had 'esophageal perforation' on the upper of his esophagus; his lung became infected and he suffered a serious complication that led to his right lung pleural thorax cavity almost collapsing. In holding the defendants to be in breach of the standard code of practice in giving the plaintiff Milo, the court went on to consider whether the plaintiff had established by evidence that the oral tablets and the Milo are the probable or material cause of the lung infection suffered by the plaintiff ie the causation effect of such breaches. The court referred to the Court of Appeal decision in *Dr Chin Yoon Hiap v Ng Eu Khoon & Ors and other appeals* [1998] 1 MLJ 57; [1998] 1 CLJ 533 on the issue of causation and whether the tortious act did or did not cause the injury to the plaintiff and quoted what His Lordship Malek Ahmad JCA (as he then was) had cited with approval the case of *Wilsher v Essex Area Health Authority* [1988] 1 All ER 871 as follows:

> ... where a plaintiff's injury was attributable to a number of possible causes, one of which was the defendant's negligence, the combination of the defendant's breach of duty and the plaintiff's injury did not give rise to a presumption that the defendant had caused the injury. Instead, the burden remained on the plaintiff to prove the causative link between the defendant's negligence and his injury.

[58] The court then went on to find that there was no evidence of causal link between giving of the tablets or the Milo and the infection suffered by the plaintiff.

[59] Having heard the submissions by both parties in the instant case, I must say that from the facts and evidence in the present case, I agree with the submission by learned senior federal counsel for the defendants that there is no

causal link between the acts and treatment provided by the defendants' servants and agents which caused the deceased to suffer SAH nor to cause the death of the deceased or that it was due to any delay in diagnosis of the deceased that caused the deceased to die. The deceased had suffered from SAH with probable ruptured of cerebral aneurysm where the mortality is almost 100%. Thus any surgical intervention would not have help in saving her life. In addition, cerebral aneurysm is a weakness in the blood vessels which is usually congenital or hereditary or due to diseases or infection of the blood vessel. There was no trauma in the deceased's case to attract early suspicious of intracranial bleed. No evidence was led to prove the causal link between SAH with probable cerebral aneurysm with any negligent act of the defendants. From Dr Johari Siregar's evidence the GCS score of a patient can drop suddenly and not gradually as suggested in cross-examination. Because of this unfortunate sudden drop in the deceased's GCS score from 14/15 to 8/15 that the index of suspicion warranted a CT scan to be carried out. Dr Suhaila had ordered CT scan immediately but Kepala Batas Hospital had no such facilities and the deceased was therefore sent to Seberang Jaya Hospital which is the nearest hospital with such facilities. However, when the results confirmed the deceased was having SAH, it also showed that there were massive bleeding in her brain with coning and that seems nothing could be done to save her since mortality was almost 100%. Therefore, whether the deceased was to be sent directly from Seberang Jaya Hospital to Penang Hospital or that she had been sent back to Kepala Batas Hospital before leaving for Penang Hospital would have not changed the outcome as there appeared no prospect of saving her life. In any event, as stated by the Court of Appeal in *Dr Chin Yoon Hiap v Ng Eu Khoon & Ors and other appeals*, where the deceased's injury or cause of death was attributable to a number of possible causes, one of which was the defendant's negligence, the burden is on the plaintiff to prove the causal link between the defendants' negligence and the deceased's injury or cause of death. In the circumstances of this case, I find that the plaintiff has failed to prove the causal link between the death of the deceased and the alleged negligence of delay in sending the deceased from Seberang Jaya Hospital to Penang Hospital. Whether there was delay or no delay in sending the deceased from Seberang Jaya Hospital to Penang Hospital, it would not have changed the end result and the fact that there is no prospect of saving the deceased's life as SAH with cerebral aneurysm attracts almost 100% mortality.

CONCLUSION

[60] Having evaluated the case as a whole, I find from the facts and evidence adduced that Dr Suhaila's report, exh D20 is to be accepted and accorded with necessary weight on the facts which were supported by her records in D19, by Dr Nor Hafizah (SD2) and by Dr Johari Siregar (SD8) as had been referred to and discussed earlier. I also find Dr Suhaila's act of admitting the deceased for

further observation and investigation when there was no symptoms of severe headache and vomitting except for complaint of dizziness when the deceased was first examined by her, to be reasonable of a medical officer of such skill or competence bearing in mind that the deceased's complaints of severe headache and vomitting at Klinik Bersatu could probably be relieved by the injection of Volteran before she presented herself at Kepala Batas Hospital. Investigations were carried out on the deceased such as GCS score taken, blood samples taken for test, fundoscopy was done etc and the deceased was kept under her close observations where she had seen the deceased twice between 2.20pm to before 4.30pm. As to treatment, Dr Suhaila had given infusion fluid to the deceased which Dr Johari Siregar opined to be proper. When the deceased's GCS score had suddenly dropped at 4.30pm to 8/15, she immediately made arrangement to send the deceased for CT scan at Seberang Jaya Hospital which is the nearest hospital with such facilities and had directed Dr Nor Hafizah to accompany the deceased in the ambulance. Dr Nor Hafizah who was informed at about 4.53pm, arrived at around 5.05pm, examined the deceased, intubated to stabilise the deceased and prepared all necessary equipment to accompany the deceased to Seberang Jaya Hospital. The ambulance left at 6.40pm. A CT scan was done at 6.55pm. Evidence also shows that there was no question of ambulance with faulty engine or lack of petrol which appears to be a miscommunication between the plaintiff and Dr Suhaila or SD7, the Director of Kepala Batas Hospital at the material time. The CT scan results most unfortunately disclosed the deadly massive bleeding in the deceased's brain that Dr Johari Siregar had opined that there is no prospect of the deceased surviving from SAH with probable cerebral aneurysm which carries with it almost 100% mortality. With that outcome, it matters not whether the deceased was sent immediately to Penang Hospital from Seberang Jaya Hospital or from Kepala Batas Hospital. There is no trauma which caused the haemorrhage in the deceased's brain. The SAH in the deceased's case was probably congenital or hereditary as blood investigation did not reveal any abnormality. Thus, causal link to negligence or delay in sending the deceased to Penang Hospital for neurosurgical intervention is doubtful and/or not proved by the plaintiff.

[61] On a balance of probabilities, basing on the *Rogers v Whitaker* test, this court holds upon finding of facts that the plaintiff has failed to prove a breach of the duty of care or negligence on the part of the servants and/or agents of the defendants relating to the deceased nor has the plaintiff proved the causal link between the cause of death of the deceased which is SAH probable cerebral aneurysm and any negligent act of the defendants' servants or agents. This court sympathises with the plaintiff and his family for the demise of the deceased but it is unfortunate that the deceased had suffered from such a deadly ailment which is congenital or hereditary, in the absence of any trauma which is an undisputed fact and in the absence of any infection in the blood of the

deceased, that mortality seems inevitable. The plaintiff's claim is therefore dismissed with costs of RM10,000 to the defendants.

Plaintiff's claim dismissed with costs.

Reported by Andrew Christopher Simon